

11516

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. HS 19

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN <u>XX</u> OF ESTI- DEATH MATED <input type="checkbox"/>	MONTH <u>JULY</u>	DAY <u>12</u>	YEAR <u>1987</u>	2b. HOUR <u>M</u>
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH <u>Sept.</u> DAY <u>14</u> YEAR <u>1946</u>	6. AGE (IN YEARS LAST BIRTHDAY) 40 yrs.	IF UNDER 1 YR. MONTHS <u></u>	IF UNDER 24 HRS. DAYS <u></u>	2c. DATE PRONOUNCED DEAD MONTH <u>APR</u> DAY <u>12</u> YEAR <u>1987</u>	2d. HOUR <u>PM</u>			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County,			MD.		
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Super.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13. STATE Md.		13b. COUNTY Prince George	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 1561 Main St.		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
14. FATHER'S NAME FIRST Carroll		MIDDLE G	LAST Alvey	15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE G	LAST Hoffman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-54-5842		17. INFORMANT Roy H. Alvey		ADDRESS Box 136 Valley Lee, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gove rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES XX NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> TITLE (SPECIFY) <u>Assistant</u> MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201								DATE SIGNED 4-13-87
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-16-87		23c. NAME OF CEMETERY OR CREMATORIAL Old Fields Cemetery		23d. LOCATION CITY OR TOWN Hughesville, Charles, Md.		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Jean S. Johnson						

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this certificate be executed within 24 hours after death. Page 4 may be continued on back.

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use at the burial permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death. Fill in Part 1 of the Burial Permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or items 38 thru 40 show any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8	7	REG. NO. 115	1	1	5	1		
1. FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT) GIUSEPPE C. ANELLO			1b. DATE OF DEATH MONTH DAY YEAR 04 01 87			2b. HOUR 4 PM					
3. SEX M Male			4. RACE C White			5. DATE OF BIRTH MONTH DAY YEAR March 21, 1895			6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS					
7a. BIRTHPLACE COUNTRY Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County					
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCLUDE FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a. USUAL OCCUPATION (TYPE OR WORK OR MOST OF WORKING) Retired coal Miner			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3367 H N. Chatham Rd 21043		
14. FATHER'S NAME FIRST Franceso			MIDDLE P. S.			LAST Scopelliti			15. MOTHER'S MAIDEN NAME FIRST Beatrice			MIDDLE Mazzotta		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS								
Yes			236 10 3303			Mrs Teresa Anello 3367 H N. Chatham Rd 21043								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						PNEUMONIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 DAYS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF CIRRHOSIS OBSTRUCTIVE PULMONARYOS 20 yrs								
(c)						DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PARKINSONS DISEASE														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 3/31/87 to 3/31/87 , that (I) (we) last saw the deceased alive on 3/31/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Scott J. Maurer MD			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10772 HICKORY RIDGE COLUMBIA 21044								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 4 '87			23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Harry H. Witzke & Family Funeral Home Inc			ADDRESS 4112 Old Columbia Pike Ellicott City			25a. DATE REC'D. BY REGISTRAR APR - 2 1987			25b. REGISTRAR'S SIGNATURE John D. [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be witnessed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 contains any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Marion I. Beaver							4-2-87				12 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH	DAY	YEAR	65	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA					Howard County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY		
Columbia		Howard County General		Homemaker						Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
				Maryland		Montgomery	Wheaton			2702 Henderson Ave., 20902		
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				Paul	B.	Ward Waid	FIRST	Helen	MIDDLE	Josephine	LAST	Schreckengast
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
(YES, NO OR UNKNOWN)				N/A		159-24-9399		Deborah L. Flynn-daughter-(same as 13e)				
PART 1. DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u>								
				DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u>								
				DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Urinary Tract Infection</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-28-1987</u> to <u>4-2-1987</u> , that (I) (we) last saw the deceased alive on <u>4-1-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED		
Dr. Shailendra Kumar								<input checked="" type="checkbox"/>	<input type="checkbox"/>		4-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				7710 Carroll Ave. Takoma Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		4-6-1987		Arlington National		Arlington		Virginia				
24. FUNERAL DIRECTOR		11800 N.H. Ave. ADDRESS		S.S. Md. 20904		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Hines/Rinaldi Funeral Home						APR-3 1987		<u>Julie Gordon-Randall</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial permit. Then please remove carbon imprint. Please send 2 copies to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If item 21 is marked "No", show any injury, or other traumatic event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 7 REG. NO. 11 5 19														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR				
BERNARD LEONARD CAESAR, JR.							04	06	87					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		BLACK		MONTH 04 DAY 10 YEAR 1939			47			MONTHS		DAYS		
YRS.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			HOWARD CO., MD.				
MARYLAND		U. S. A.								ELLIOTT CITY, MARYLAND				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (WORK OR LEISURE WORKING LIFE)			13. STREET ADDRESS / ZIP CODE			COMPUTER ENGINEER WESTINGHOUSE ELLICO CITY, MD.				
ELLIOTT CITY		8874 TOWN AND COUNTRY BOULEVARD		SYSTEM ANALYST			8874 TOWN & COUNTRY BLVD. APT. D							
13b. STATE MARYLAND		13c. CITY OR TOWN ELLIOTT CITY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			ELLIOTT CITY, MD.				
14. FATHER'S NAME FIRST BERNARD		MIDDLE L.		15. MOTHER'S MAIDEN NAME FIRST MARIE			MIDDLE E.			LAST HILLERY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES VIETNAM		17. INFORMANT MRS. MARIE E. CAESAR			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			BALTIMORE, MARYLAND 3109 GWYNNS FALLS PKWY. 21216				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Britt o Diabetes Mellitus</u>		DUE TO, OR AS A CONSEQUENCE OF (b) _____			DUE TO, OR AS A CONSEQUENCE OF (c) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Tachemic heart disease. Seizure disorder</u>														
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 4/8/87				
22c. SIGNATURE <u>William Flowers</u> DEGREE M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 11055 Little Patuxent Pkwy Columbia Md												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 4/11/1987		23c. NAME OF CEMETERY OR CREMATORIAL GARRISON FOREST VETERAN			23d. LOCATION CITY OR TOWN			BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR NAME NOTRE & SONS FUNERAL HOME, INC.		25a. DATE REC'D. BY REGISTRAR APR 14 1987								25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				
ADDRESS 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216														

4/20

1030 P.M. 295A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or Item 18, more than one injury or other traumatic event, the medical certification must be signed at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 11520

1. DECEASED NAME Alice			FIRST	MIDDLE	LAST	2a. DATE OF DEATH April 9, 1987	MONTH APR	DAY 9	YEAR 1987	2b. HOUR 4:40 P.M.
			Chester							
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 22, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard				MD.
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9321 Michaels Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Social Security Adm.				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) THE STATE MD		13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9321 Michaels Way 21043				
14. FATHER'S NAME FIRST John Lucas			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Thesia Payne		MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 208-16-6358		17. INFORMANT Wilmer Chester		Ellicott City MD 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Respiratory Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Cervical Cancer - Metastatic							
			DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Malnutrition, Renal Failure, COPD, Chronic Anemia, Bowel obstruction										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 1985 to April 1987 , that (I) (we) last saw the deceased alive on April 1, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Jon K. Minford</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon K. Minford M.D.		22e. ADDRESS 10806 Hickory Ridge Road, Columbia, MD. 21046								
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 04/11/87		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Cemetery		23d. LOCATION CITY/TOWN Marietta		COUNTY	STATE	
24. FUNERAL DIRECTOR TERRY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 TH EDMONDSON AVE., CATONSVILLE, MD. 21228		25a. DATE REC'D. BY REGISTRAR APR 14 1987		25b. REGISTRAR'S SIGNATURE <i>Lilia Dideron-Redace</i>						
DHMH - 16 60M 7/84 (VRA 15, 4)										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-travel permit. It should be retained by the funeral director until the body is removed or until the date of interment or cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, it is the duty of the medical examiner to notify the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
87 NO. 11521															
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	HOUR		
Therma Copeland									4/4/87	APR	4	1987	2:15 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH			MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
F	W		31/16/13						74	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
VA.	USA								Howard County						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Columbia	Howard County Hospital										Retired		NURSE HOSPITAL		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS ZIP CODE			MD.						
Ma	28224	Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3539 Wilkens Ave. 21229									
14. FATHER'S NAME	FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			LAST		16. DEVERICKS			
Lucius					Neil		Blanche								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO	217-30-4903		Mr. Herbert Copeland - Same as #13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____															
DOUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
DOUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal failure															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/29/87, 1987, to 4/4/87, 1987, that (I) (we) last saw the deceased alive on 3/29/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Marc Damaw				DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/5/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marc Damaw MD				22e. ADDRESS 905 BARTON Place Md 21043											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 4-6-87			23c. NAME OF CEMETERY OR CREMATORIAL LOCATION CITY OR TOWN			23d. LOCATION CITY OR TOWN			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME State Anatomy Board										25a. DATE REC'D. BY REGISTRAR APR 09 1987			25b. REGISTRAR'S SIGNATURE Julia Benson-Randall		
ADDRESS Balto., Md.															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death record be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 7 REG. NO. 11522											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR
MARIA Czerchowaska						4 17 87			200	PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			C			MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
Ukraine			Canada			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
10. CITY OR TOWN OF DEATH Columbia			Howard County General			13a. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION			13b. STREET ADDRESS / ZIP CODE 6342 Beechwood Dr. 21046		
13a. STATE Md.			13b. COUNTY Howard			13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Profirius			FIRST	MIDDLE	Wasyluk	15. MOTHER'S MAIDEN NAME Katarina			MIDDLE	LAST Kowal	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 213-46-3688			17. INFORMANT Stephanie Iwaskiw			6342 ADDRESS Beechwood Dr. Columbia, Md. 21046		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Scav</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Stroke</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>4/13</i> , 19 <i>87</i> , to <i>4/17</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>4/12</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Say Rendon</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/20/87</i>		
22d. PHYSICIAN'S NAME <i>Say Rendon</i>			22e. ADDRESS <i>11055 Little Patuxent Colm</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/20/87			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland Maryland		
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home 9013 Annapolis Rd. Lanham, Md. 20706						25a. DATE REC'D. BY REGISTRAR APR 29 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Rendon-Lanham</i>		

TEST 01.12.2014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 may be used for the burial/transit permit. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
87 REG. NO. 11523											
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN	MIDDLE J.	LAST DANAKER	JR.	2a. DATE OF DEATH	MONDAY	DAY	7	YEAR	87
John J.				Danaker		8	DA 22	YEAR	40		2. HOUR
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		MONTH DAY YEAR		46		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Howard COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Columbia		Howard County General Hospital		ROUTE SALESMAN		BAKERY					
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Md		Howard		Columbia		10334 Night Mist Ct 21044					
14. FATHER'S NAME		FIRST JOHN	MIDDLE J.	LAST DANAKER SR.	15. MOTHER'S MAIDEN NAME	FIRST PHYLLIS	MIDDLE	LAST CHAMBERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		214-38-7438		BONNIE L. DANAKER		10334 NIGHT MIST CT. COLUMBIA, MD. 21044					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Small cell CA of lung - metastatic. APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 6 months											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral metastases, chronic anemia, lung collapse											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 86 to April 19 87, that (II) (we) lost saw the deceased alive on April 1 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jon Minford		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-7-97					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon Minford		22e. ADDRESS 1080G Hickory Ridge Rd				COLUMBIA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/9/87		23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE		23d. LOCATION CITY OR TOWN DORSEY		COUNTY		STATE MARYLAND	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045				25a. DATE REC'D. BY REGISTRAR APR 10 1987		25b. REGISTRAR'S SIGNATURE in Davidon-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial permit. Then please remit carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being due to any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11504

1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>ROBERT</i>	MIDDLE <i>L. L.</i>	LAST <i>DAVIDSON</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>4-1-87 1923M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY <i>2-11-29</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>58</i>	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>0 0 0 0</i>
8. BIRTHPLACE COUNTRY <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MD. <i>Howard County,</i>	10. CITY OR TOWN OF DEATH <i>Columbia Howard County Gen Hosp</i>
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Engineer</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>C & P Tel</i>	13b. STATE <i>MD</i>	13c. COUNTY <i>Howard</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <i>21043</i> <i>9217 Frederick Rd.</i>
14. FATHER'S NAME FIRST <i>Henry</i>	MIDDLE <i>E.</i>	LAST <i>Davidson, Sr.</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Beatrice</i>	MIDDLE <i>--</i>
LAST <i>Murray</i>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>Korean 219226760</i>	17. INFORMANT ADDRESS <i>Ellicott City, Md. 21043</i>	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immed</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	<p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Tachycardia</i> recent</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Disease</i> 12 yrs.</p>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10.				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>3/25 1976</i> to <i>3/25 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. I (we) did (did not) view the body after death.				
22b. SIGNATURE <i>M. KELLEMEN</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED <i>4/1/87</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>4/4/87</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Druid Ridge Cemetery - Baltimore, Md.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Sterling Funeral Estate, P.A.</i>	ADDRESS <i>736 Edmondson Avenue; Catonsville, Md. 21228</i>	25a. DATE REC'D. BY REGISTRAR <i>APR - 3 1987</i>	25b. REGISTRAR'S SIGNATURE <i>Lilia Davidson-Randall</i>	

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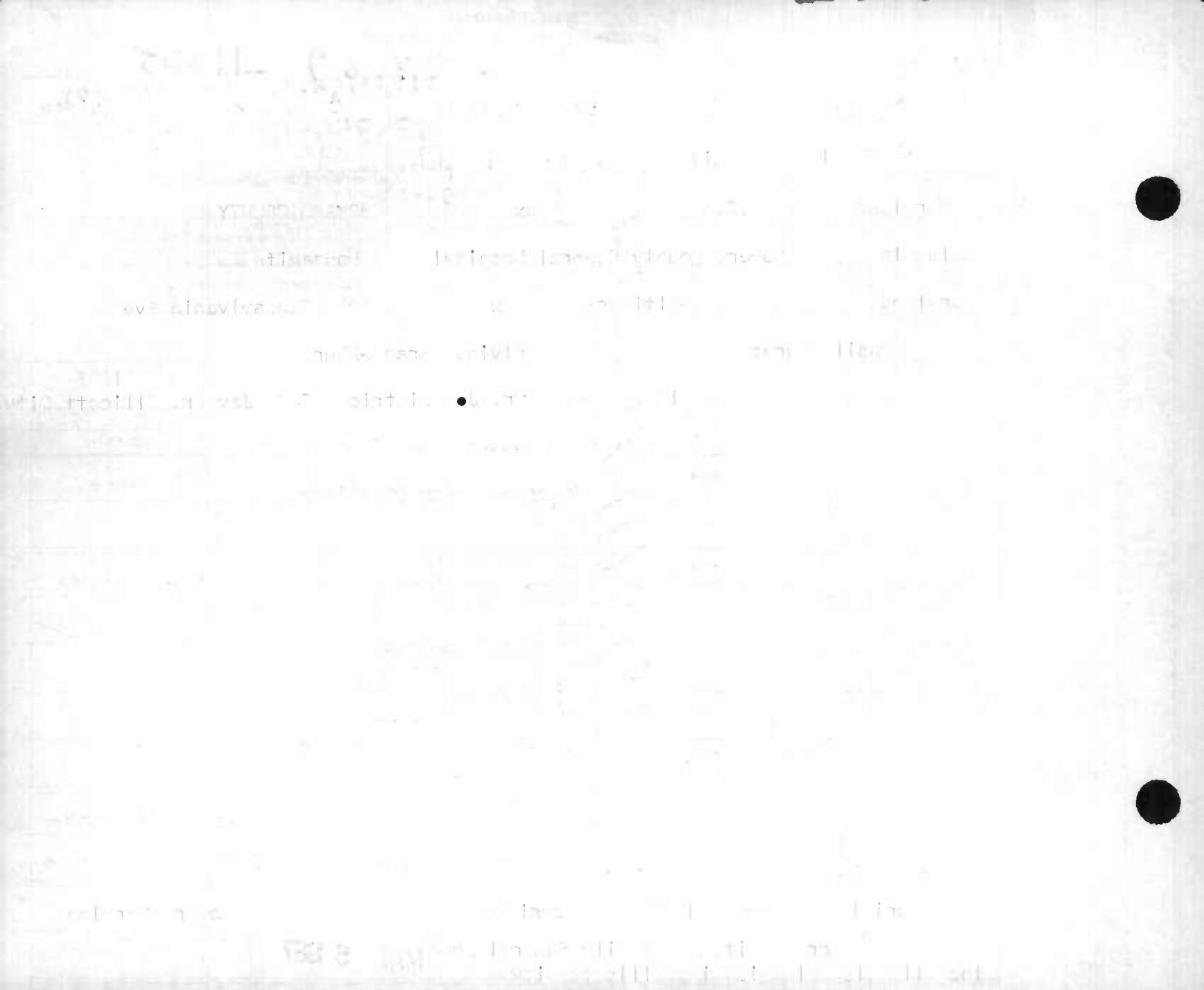
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and page 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted before filing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH	MONTH	DAY	YEAR	REG. NO.	8911525
MINNIE V DIGTRICH						DATE OF DEATH	MONTH	DAY	YEAR		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE IN YEARS (BIRTHDAY)			7. IF UNDER 24 HRS	
F Female			White	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	HOURS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.						HOWARD COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Columbia			Howard County General Hospital			Housewife					
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b COUNTY			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE		
Maryland			Baltimore						2900 Pennsylvania Ave 21217		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Basil Burns			Alvina Brandenburg			213 74 4609			Mr. Joe Dietrich 3434 Jay Dr. E. ELLICOTT CITY 21043		
18a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b SOCIAL SECURITY NO.			18c APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			213 74 4609			24H					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Inferior myocardial infarction 24H.								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a metabolic acidosis, obstructive pulmonary disease, acute renal failure, probably septic.											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
—			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET — CITY OR TOWN — COUNTY — STATE —					
22a I certify that (I) (this hospital) attended the deceased from 4/29/87 to 4/30/87, that (I) (we) last saw the deceased alive on 4/30/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
22b PHYSICIAN'S NAME (TYPE OR PRINT)			22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED		
PATRICE A. TATE, MD									4/30/87		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN		
Burial			May 2, 1987			Meadowridge			Howard County Maryland		
24 FUNERAL DIRECTOR NAME			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Harry H Witzke & Family Funeral Home Inc 4112 Old Columbia Pike ELLICOTT CITY			MAY 6 1987			Julia Sanderson-Kendall					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

82 REG. NO. 11526

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
HELEN E. EITZE						APRIL	8	1987	2408			
1. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		CAUcasian		MONTH	DAY	YEAR	48	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD County		MD.				
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORTEN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY						
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 39 Carling Cir. #21227		Balto., Md.				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Louis			Otto	Mary			Pickett					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 216-32-4411		17. INFORMANT IMMEDIATE CAUSE (a) Cardio - pulmonary arrest		ADDRESS 39 Carling Circle-Baltimore, Md. #21227		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mins.				
				(b) Metastatic adenocarcinoma				3 months.				
				(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
18. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I/we) attended the deceased from 4/7/87 to 4/8/87 , that (I/we) last saw the deceased alive on 4/7/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> SIGNATURE Charles E. Shreehan III MD DEGREE												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Shreehan III MD		22e. ADDRESS		22f. DATE SIGNED 7/7/87								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 10, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Balto.		COUNTY		STATE		
24. FUNERAL DIRECTOR G. Truman Scowab		24b. ADDRESS 3512 Frederick Ave #21229		24c. DATE REC'D BY REGISTRAR APR 15 1987		24d. REGISTRAR'S SIGNATURE Jeanne Shreehan Landress						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use of the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

REMAINDER OF FORM IS FOR REGISTRAR USE ONLY

4/14

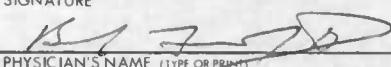


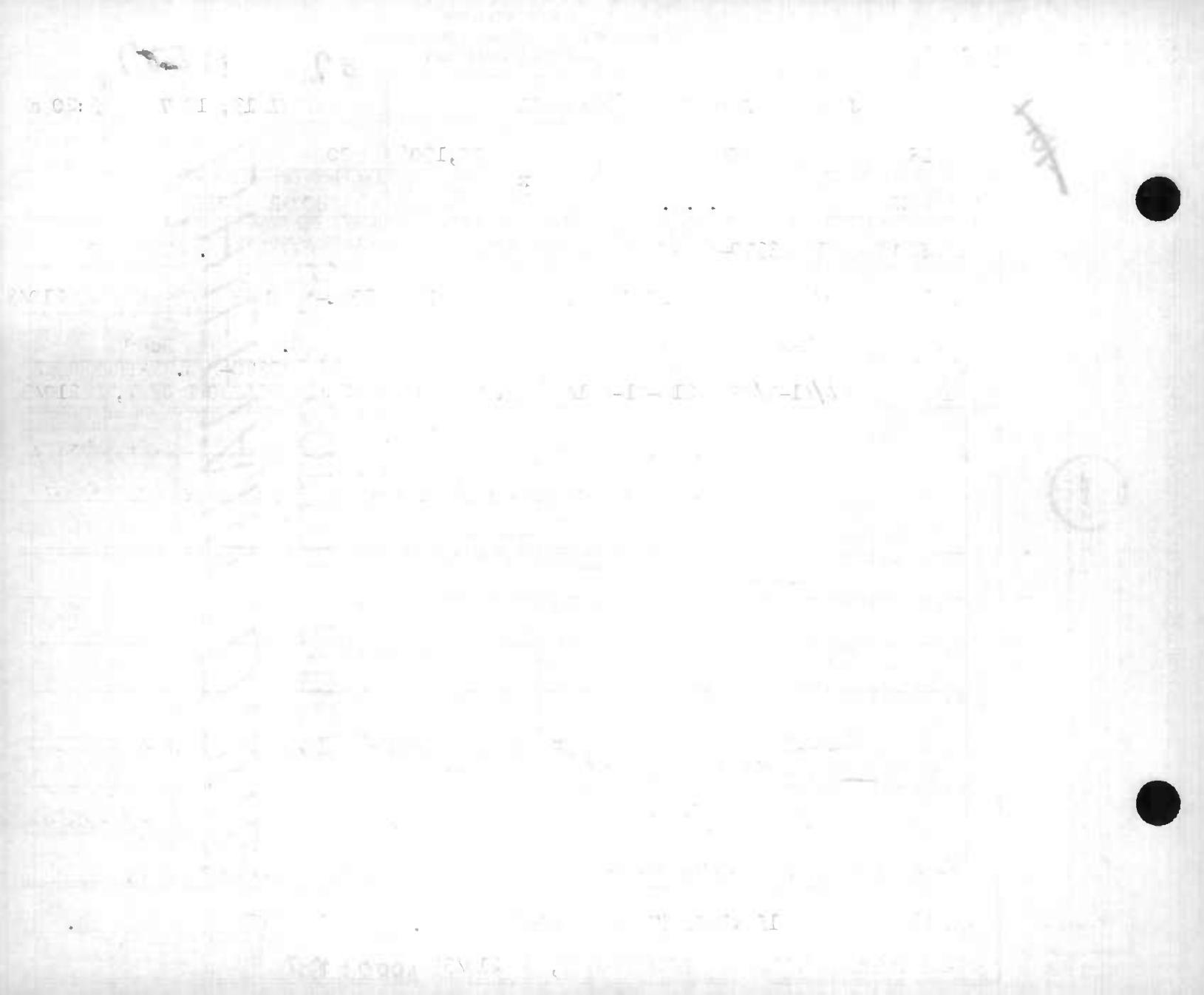
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, removal, or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 82 11529											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR
JAMES JOSEPH FARRELL						APRIL 13, 1987			5	13	1987
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
MALE			WHITE			MONTH DAY YEAR DECEMBER 20, 1906			80 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.						HOWARD COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
ELLIOTT CITY			3370-F NORTH CHATHAM ROAD			UNDERWRITER SUP.			USF & G		
13a. STATE MARYLAND			13b. COUNTY HOWARD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ZIP CODE 3370-F NORTH CHATHAM ROAD 21043		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
JOHN THOMAS FARRELL			CATHERINE CO. DeBOY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF EVER GAVE WAR OR DATES) 4/21-9745			17. INFORMANT MS. MADELINE FARRELL			ADDRESS 3370-F N. CHATHAM ROAD ELLIOTT CITY, MD 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1+ years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease						1+ years		
			DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) March 1987			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 10, 1987 to 4/13/1987, that (I) (we) lost saw the deceased alive on March 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE 			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD P. FARRELL MD						22e. ADDRESS 11055 Little Patuxent Pkwy Columbia, MD 21046					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 15 APRIL 87			23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL CEM.			23d. LOCATION CITY OR TOWN BALTIMORE COUNTY STATE		
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			ADDRESS ELLIOTT CITY, MD 21043			25a. DATE REC'D. BY REGISTRAR APR 21 1987			25b. REGISTRAR'S SIGNATURE Julia Gordon Readell		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it should be filed in the funeral director's office. Then please remove carbon papers. Page 3 should be filed with the burial permit. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR
Howard T. Fultz, Sr.						4/25/87	APR	25	1987
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
Male		caucasian		MONTH	2	DAY	24	IF UNDER 1 YEAR	IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		YRS.	
Maryland		U.S.A.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTHS DAYS HOURS MIN.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		MD.	
Dorsey		6796 Dorsey Rd.		carpenter		self			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD	13b COUNTY Howard	13c CITY OR TOWN Dorsey		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6796 Dorsey Rd. 21227			
14 FATHER'S NAME FIRST John		MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST Minnie		MIDDLE	LAST		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT		ADDRESS Md. 21227			
yes		216 14 8488		Margaret B. Fultz 6796 Dorsey Rd., Balto.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastases from lung Cancer</u> 2 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung Cancer</u> 8 mo APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> , 19 <u>87</u> , to <u>4/25</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>4/24</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Dr. William Waterfield</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/27/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Waterfield		22e. ADDRESS St. Agnes Hospital, Wilkens & Caton Ave., Baltimore, Md. 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 4/28/87		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN Elkridge		COUNTY STATE Howard Md.	
24. FUNERAL DIRECTOR NAME Gary L. Kaufman		ADDRESS 5695 Main St., Elkridge, Md. 21227		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John J. Radke</u>			

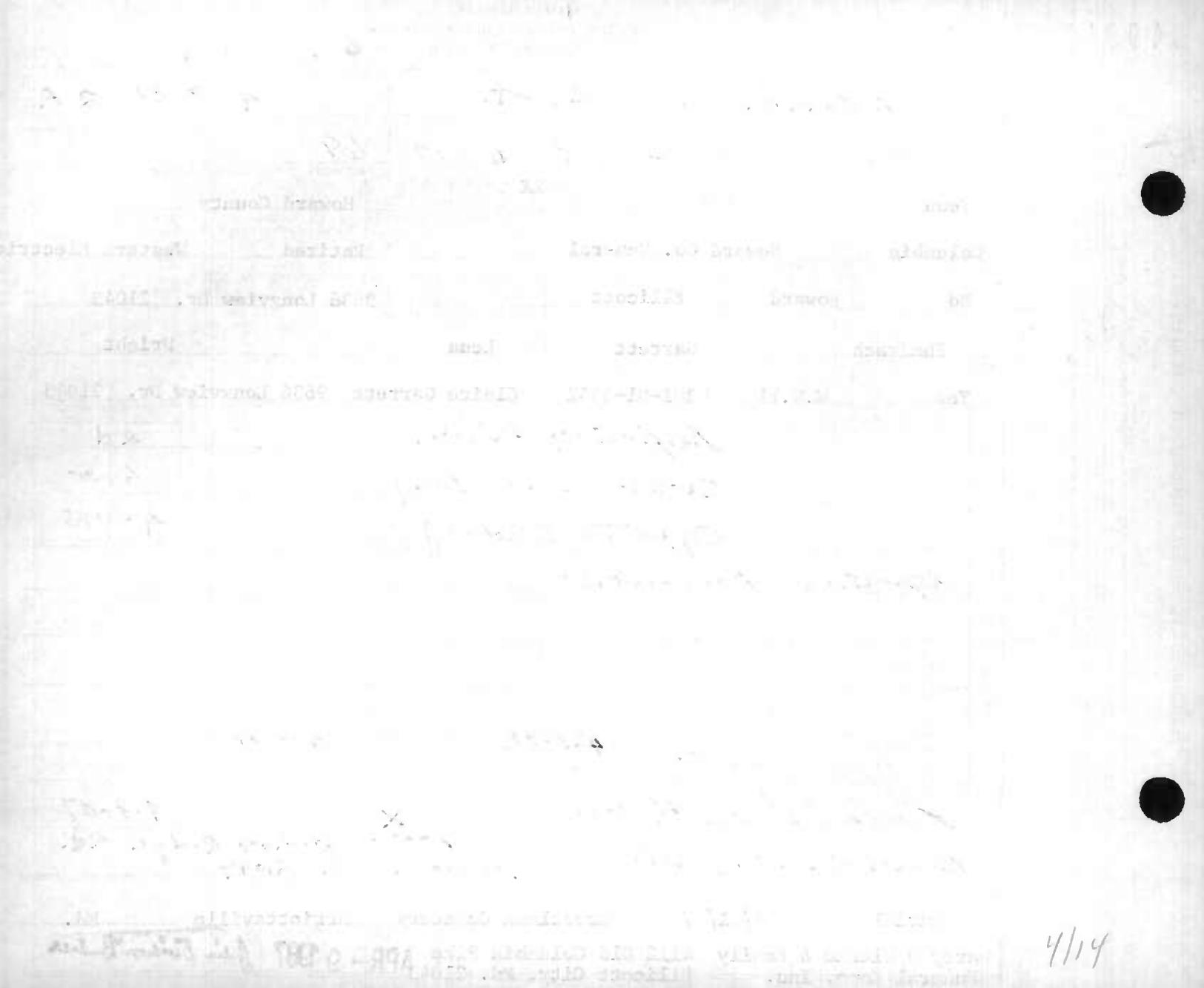


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
87 REG. NO. 11529												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Nathaniel U. Garrett						4 8 87			2 AM			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
male		white		9 1 17			69 yrs			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Tenn		USA					Howard County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Columbia		Howard Co. General		Retired			Western Electric					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Md		Howard		Ellicott						9636 Longview Dr. 21043		
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST					
Shadrach				Lena			Wright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes		W.W.11		301-01-3332			Claire Garrett 9636 Longview Dr. 21043			2d		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Lung</u> 6 mo												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cigarette smoking</u> 40 yrs												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>Aspiration Pneumonitis</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b.							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-7-87</u> , 19, to <u>4-8-87</u> , 19, that (I) (we) last saw the deceased alive on <u>4-7-87</u> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Richard W. Smith, M.D.</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4-8-87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard W. Smith, M.D.</u>		22e. ADDRESS <u>10802 Hickory Ridge Rd.</u> <u>Columbia Md. 21044</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/11/87		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Cemetery			23d. LOCATION CITY OR TOWN Marriottsville Md.					
24. FUNERAL DIRECTOR NAME <u>Harry Witzke & Family Funeral Home, Inc.</u>		25a. DATE REC'D. BY REGISTRAR APR - 9 1987										



4/14

051254 APR 22 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11530

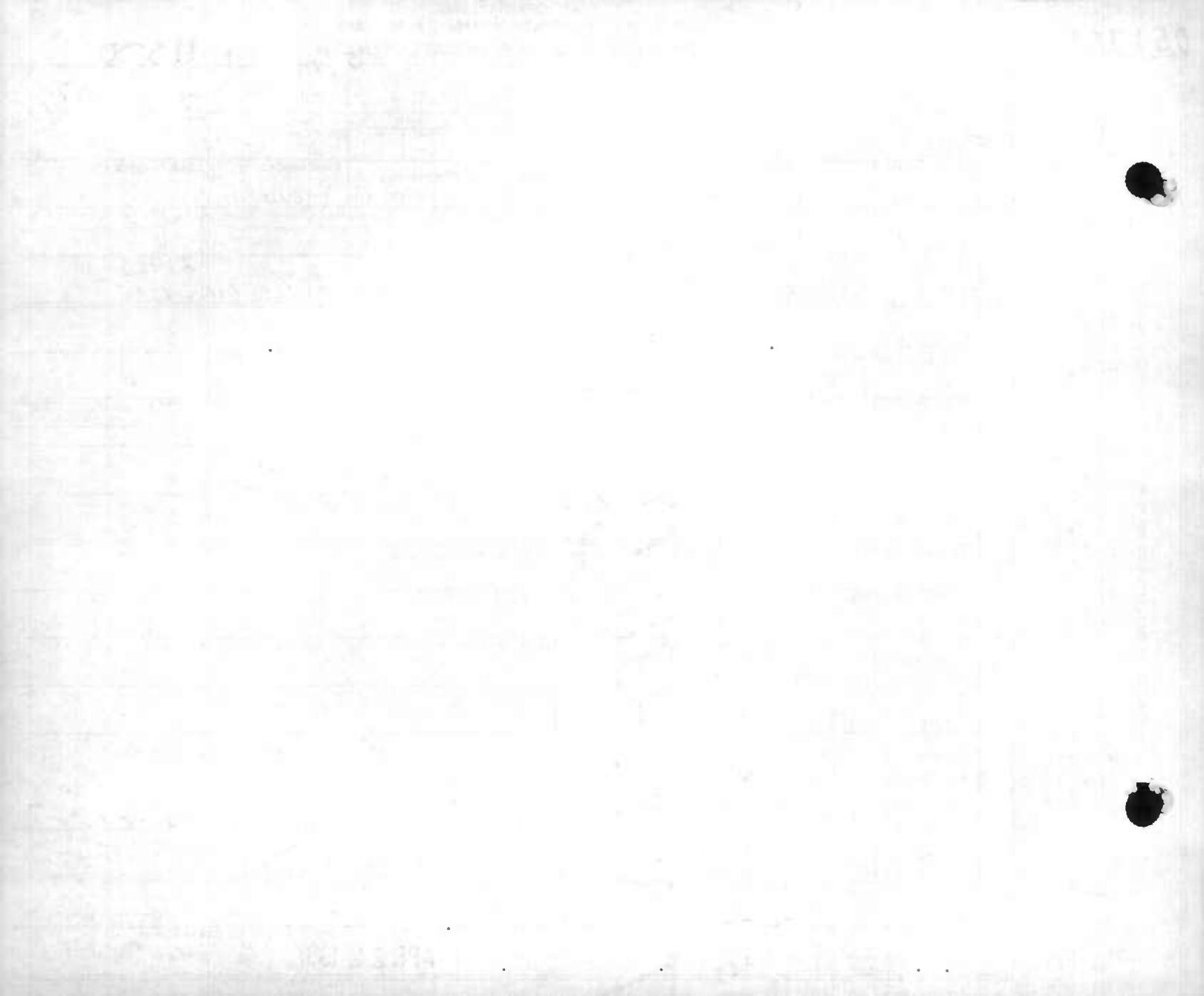
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BILL OF TRANSIT (PERMIT). PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	1b. HOUR					
<i>Natalie H. Howard</i>						<i>4-19-87</i>			4-19	87	1987	11:00 A.M.					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
FEMALE	BLACK	<i>11 11 26</i>	<i>60 yrs.</i>							<i>4-19-</i>			<i>1987</i>	<i>19</i>	<i>00</i>	<i>A.M.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND			US			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			HOWARD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
<i>Columbia</i>			<i>Howard County Gen. Hospt.</i>			PROGRAMER			21723								
13a. STATE MD			13b. COUNTY HOWARD			13c. CITY OR TOWN COOKSVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2415 MILLERS MILL ROAD					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS
ROLAND			C.	HAYWOOD	EDNA			E.	BLACKWELL	NO			216-20-2001			CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY: 911 IMMEDIATE CAUSE (a) <i>cardio-pulmonary arrest</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestion of very obstructed by food</i> } DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
												YES <input type="checkbox"/>	NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															TITLE (SPECIFY)		
ACTUAL SIGNATURE <i>Robert E. Lydick</i>			M.D.			, MEDICAL EXAMINER			DATE SIGNED <i>4-19-87</i>								
EXAMINER'S NAME (TYPE OR PRINT) <i>ROBERT LYDICK</i>			ADDRESS <i>9055 Newell St. Ellicott City, Md</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4-24-87			23c. NAME OF CEMETERY OR CREMATORIAL CRESTLAWN CEMT.			23d. LOCATION CITY OR TOWN COOKSVILLE			COUNTY MARYLAND					
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS			ADDRESS 1721 N. MONROE ST.			25a. DATE REC'D. BY REGISTRAR APR 22 1987			25b. REGISTRAR'S SIGNATURE <i>Suzia Dawson-Landess</i>								
DHMH - 17 (VR A15 ME(5)) 15M 7/77																	



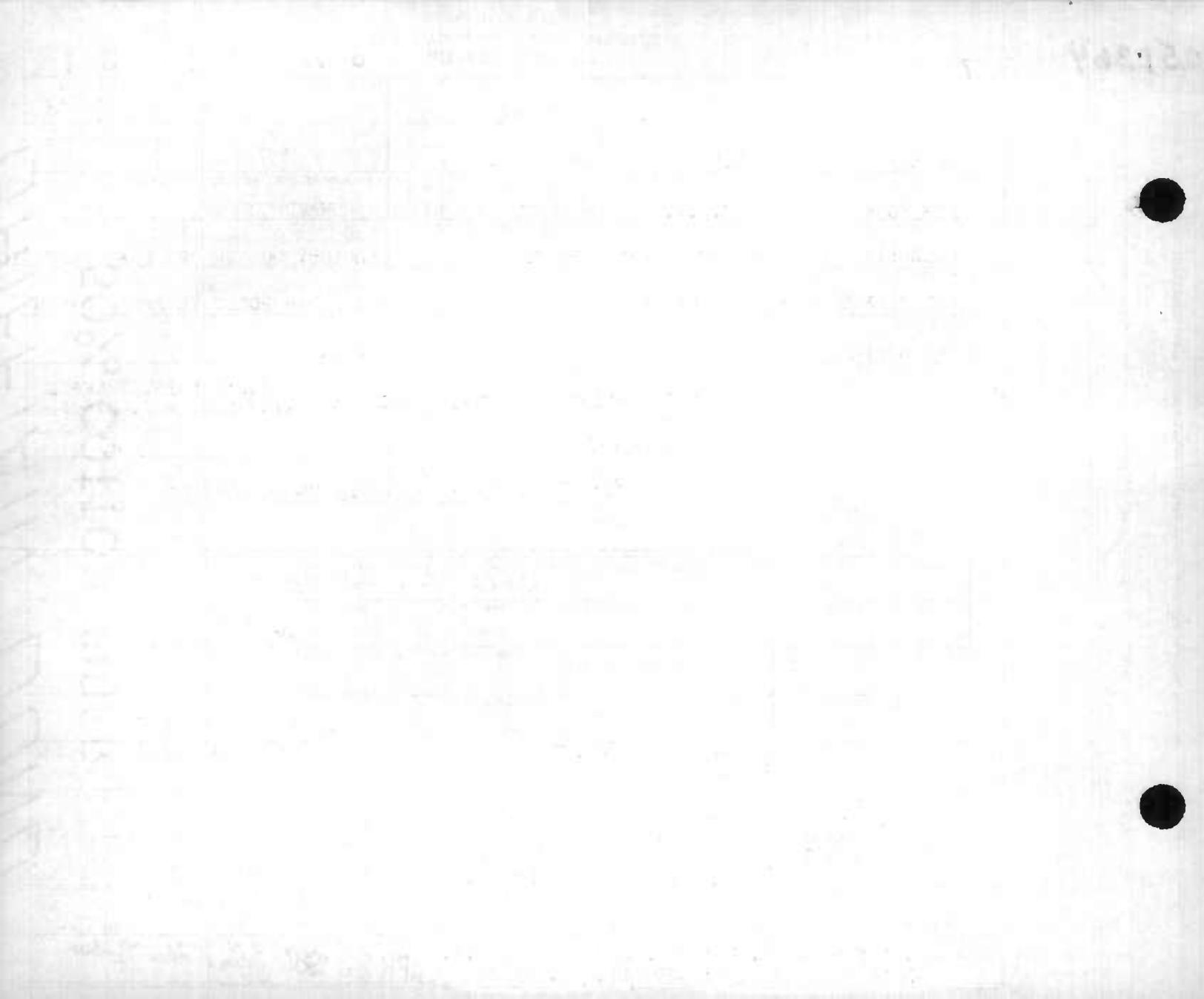
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

Film #G627, Items #13a, 13b, 13c, and 13e FOR STATE REGISTRAR			5/5/87, sjb			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			87111531 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			MADELINE P. HUGHES			2a. DATE OF DEATH MONTH DAY YEAR			4 22 87		
3 SEX FEMALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 87 yrs.		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY NEW YORK			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.		
10 CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOWARD COUNTY GENERAL			12a USUAL OCCUPATION FACTORY WORKER			12b. KIND OF BUSINESS OR INDUSTRY GENERAL ELECTRIC		
13a STATE MD. NEW JERSEY			13b COUNTY MORRIS			13c CITY OR TOWN KINNELLON Columbia			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST DANIEL McINERNEY			15 MOTHER'S MAIDEN NAME UNKNOWN			16b SOCIAL SECURITY NO. 207-14-3258			17 INFORMANT PATRICIA JARDINE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b SOCIAL SECURITY NO. WW II			17 INFORMANT PATRICIA JARDINE			ADDRESS 5 SOUTH POINT TERRACE KINNELLON, N.J. 07405		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18b DUE TO, OR AS A CONSEQUENCE OF (b)			18c DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			Pneumonia			Obstructive Pulmonary Disease			years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Ane 61 Bleeding											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN CITY OR TOWN COUNTY STATE 4122 87					
22a. I certify that (I) (this hospital) attended the deceased from 874/17, 19, to 874/17, 19, that (I) (we) last saw the deceased alive on 874/17, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE MAUREE			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 1077 HICKORY RIDGE COLUMBIA			22e. DATE SIGNED 2104/91		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/23/87			23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERANS			23d. LOCATION CITY OR TOWN GARRISON FOREST OWINGS MILLS MARYLAND		
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045			25a. DATE REC'D. BY REGISTRAR APR 23 1987			25b. REGISTRAR'S SIGNATURE Julia Sanderson Lindale					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11532

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
GILBERT N. HURT				4	26	87					M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR							
MALE		BLACK		MONTH	DAY	YEAR	64	YRS.			IF UNDER 24 HRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
VIRGINIA		US		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HOWARD			COLUMBIA							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE							
HOWARD COUNTY GENERAL HOSP.				RETIRED			MD.			MARYLAND							
13b. COUNTY				13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME				
BALTIMORE				XX			2227 RUSKIN AVE. 21217			FIRST							
WILLIAM				HURT			VIRGINIA			MIDDLE				LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ADDRESS			
YES				XX			CHART			Acute MI				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b)			ASCU D			DUE TO, OR AS A CONSEQUENCE OF				(c)			
(c)				ASCU D			age			DUE TO, OR AS A CONSEQUENCE OF				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												(ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.M.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
21g. I certify that (I) (this hospital) attended the deceased from		21h. OCT 19 72			TO APRIL 26 19 87			21i. saw the deceased alive on 24 MARCH 19 87 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE		M.D.			DEGREE			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>				4/28/87					
L. BOAS MD		5714 Harford Rd Suite 100			OWINGS MILLS			MD				21214					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL		5-1-87			Garrison Forest Vet			OWINGS MILLS				MARYLAND					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
E.L. PHILLIPS		1721 NORTH MONROE ST.			APR 28 1987			John D. Phillips									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon portion. Form 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from or the burial permit. Then please remove carbon copy of page 2 and page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
8 7 REG. NO. 1 1 5 3 3																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR <i>645 A</i>					
MICHAEL			P.		JACOBS			April 3, 1987					M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.						
MALE		WHITE		May 1, 1917			69											
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. DATE OF BIRTH MONTH DAY YEAR			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY		
PENNSYLVANIA		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			COLUMBIA			HOWARD COUNTY GENERAL			MACHINIST			COAST GUARD		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			MD					
MD		ANNAPRUL		JESSUP						2065 MONTEVIDEO ROAD			20794					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PAUL A. JACOBS					ANNA M. TKACH			192-01-8030			JESSUP ANNIE M. JACOBS			2065 MONTEVIDEO RD.				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on <u>3/31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS			22e. IN DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. KELSMAN</i>						<i>M.D.</i>			2 KNOLL NORTH COLUMBIA MD 21045			<i>4/3/87</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 04/06/87			23c. NAME OF CEMETERY OR CREMATORIUM MEADOWRIDGE CEMETERY			23d. LOCATION CITY OR TOWN DORSEY MARYLAND			23e. COUNTY			STATE			
24. FUNERAL DIRECTOR NAME: <i>R. RUSSELL C. WITZKE</i> ADDRESS: <i>FUNERAL HOMES P.A.</i>			25a. DATE REC'D. BY REGISTRAR APR - 7 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson Landreth</i>												
5555 TWIN KNOLLS RD. COLUMBIA MARYLAND 21045																		

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V O I D

8 7 - 1 1 5 3 4

NAME: Rolla R. Johnson

DOD: May 1, 1987

PLACE: Howard County



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon paper, print clearly and attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 7 REG. NO. 1 1 5 3 5												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
CHARLES A. KREATCHMAN						April 22, 1987			11:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 24 HRS		
Male		White		January 23, 1907			80			YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
Maryland		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Columbia		Howard County General Hospital		Retired Policeman								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY, OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9534 Westwood Dr. 21043						
14. FATHER'S NAME FIRST UNKNOWN		MIDDLE		15. MOTHER'S MAIDEN NAME UNKNOWN			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		16c. INFORMANT Mrs Jessica Kearchman			ADDRESS 9534 Westwood Dr. 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac death</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>86</u> CITY OR TOWN <u>4116</u> COUNTY <u>87</u> STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Scott T Maurer</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/20/87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SCOTT T MAURER</u>		22e. ADDRESS <u>2850 NORTH RIDGE 20. 21043</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25 '87		23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Cem.			23d. LOCATION CITY OR TOWN			COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR HARRY H WITZKE & FAMILY FUNERAL HOME, INC.		4112 OLD COLUMBIA PIKE ELLIOTT CITY MD 21043			25a. DATE REC'D. BY REGISTRAR APR 30 1987			25b. REGISTRAR'S SIGNATURE <u>Jessie Diodon-Randall</u>				

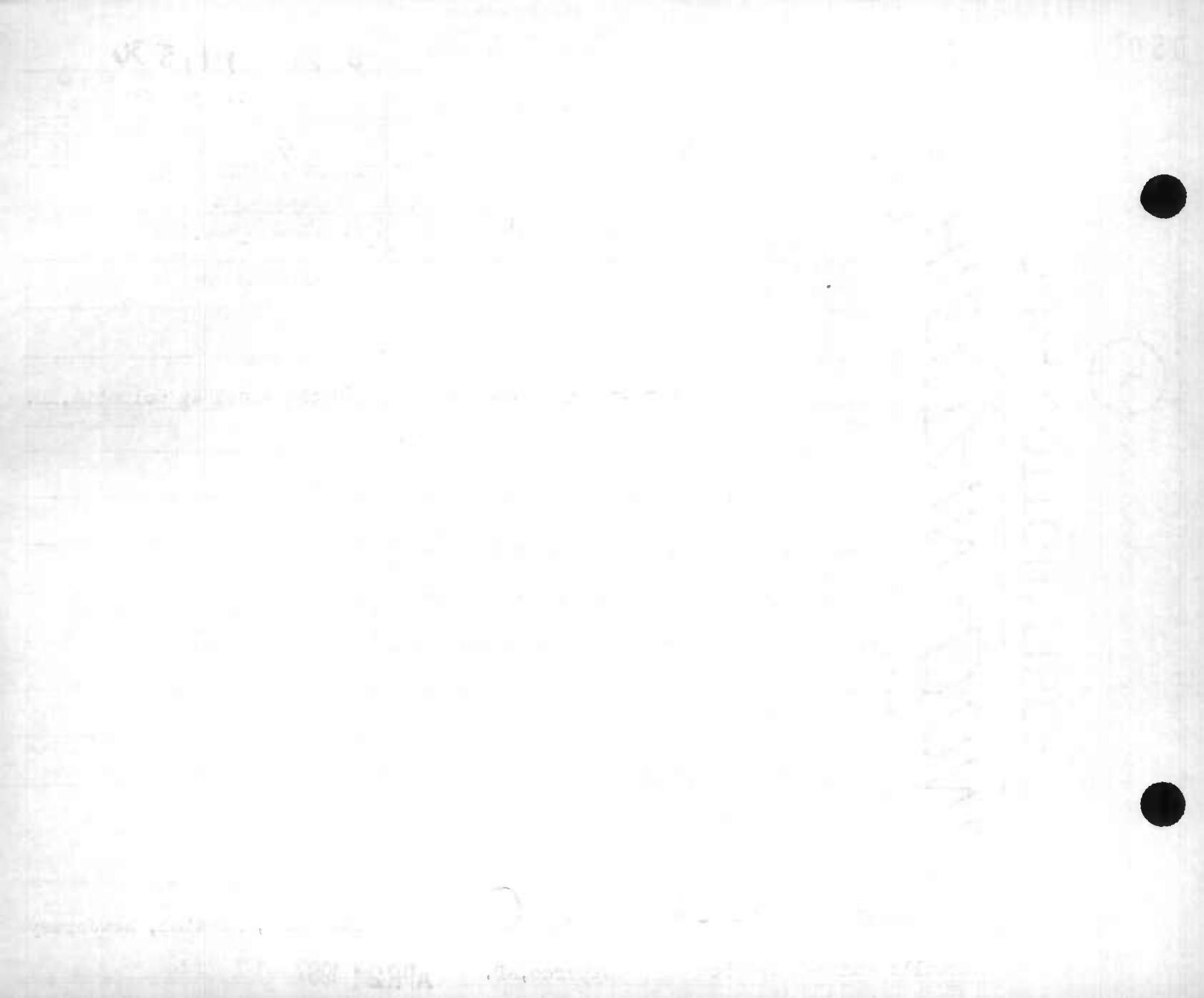
050967 APR 22 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 7 REG. NO. 111536												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR
CHARLES					LERNER			4 19 87			6:50 P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		white		MONTH 7 DAY 5 YEAR 95			91 YRS.			MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Russia		US					HOWARD Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY					
COLUMBIA		HOWARD Co GEN Hosp					Counter Man-Deli			Food		
13a. STATE MD		14. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7080 Cradle Look Way 21045		
14. FATHER'S NAME FIRST ISAAC		MIDDLE		15. MOTHER'S MAIDEN NAME LAST Chia								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		067-01-0943		Reva Lerner 7080 Cradle Look Way Columbia, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SICK SINUS in ASYSTOLE 8583 DUE TO, OR AS A CONSEQUENCE OF (b) DIGITALIS Toxicity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC CONGESTIVE FAILURE												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: MALNUTRITION ORGANIC BRAIN SYNDROME												
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/7 19 87 to 4/14 19 87, that (I) (we) lost saw the deceased alive on 4/14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE NESTOR F DE VENECIA		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/19/87				
22e. ADDRESS 10810 HICKORY RIDGE ROAD COLUMBIA MD 21044												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-21-87		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Park Cemetery			23d. LOCATION CITY OR TOWN Westwood, Passiac, New Jersey		COUNTY	STATE		
24 FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, MD.			25a. DATE REC'D. BY REGISTRAR APR 21 1987			25b. REGISTRAR'S SIGNATURE John Fidler, Jr.				
DHMH - 16 60M 7/B4 (VRA 15, 4)												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Parties 1 and 2 should be filled within 72 hours after death. Please do not sign this certificate until it has been filled out and checked by the funeral director.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this section of the form must be completed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 7 REG. NO. 1 1 5 3 7											
1. FOR STATE REGISTRAR A.K.A. NHUNG THI DOAN			2a. DATE OF DEATH MONTH 4 DAY 9 YEAR 87			2b. HOUR 5P M					
1. DECEASED NAME FIRST Nhung MIDDLE THI LAST Luu			5. DATE OF BIRTH MONTH 6 DAY 6 YEAR 35			6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS					
3. SEX FEMALE			4. RACE ASIAN			7. IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vietnam			7b. CITIZEN OF WHAT COUNTRY? VIETNAM			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10799 Hickory Ridge Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY HOME 21044		
13a. STATE Md.			13b. COUNTY Howard			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10799 Hickory Ridge Rd.		
14. FATHER'S NAME FIRST AN MIDDLE VAN LAST DOAN			15. MOTHER'S MAIDEN NAME FIRST NGHI MIDDLE THI LAST NGUYEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 439-81 9156			17. INFORMANT HIEP HOA LUU - Same as Sec. 13			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cardiac Arrhythmia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DOUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease						20 yrs		
			DOUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Porcine prosthetic mitral valve; old massive Cerebrovascular Accident											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from approx 1981 to approx March 19 87, that (we) lost saw the deceased alive on March 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I was (not) (did) (did not) view the body after death.)											
22b. SIGNATURE Richard W. Smith M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-9-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Smith M.D.			22e. ADDRESS 10802 Hickory COLUMBIA, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 04-13-1987			23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Cemetery			23d. LOCATION CITY OR TOWN Marriottsville COUNTY Howard STATE MD.		
24. FUNERAL DIRECTOR (NAME) Leroy M. & Russell C. Witzke Funeral Homes P.A. ADDRESS 5555 Twin Knolls Rd., Columbia, MD. 21045			25a. DATE REC'D. BY REGISTRAR APR 14 1987			25b. REGISTRAR'S SIGNATURE via Daidon. Randa					

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1960-1961 - 1962-1963 - 1963-1964

1964-1965 - 1965-1966 - 1966-1967

1967-1968 - 1968-1969 - 1969-1970

1970-1971 - 1971-1972 - 1972-1973

1973-1974 - 1974-1975 - 1975-1976

1976-1977 - 1977-1978 - 1978-1979

1979-1980 - 1980-1981 - 1981-1982

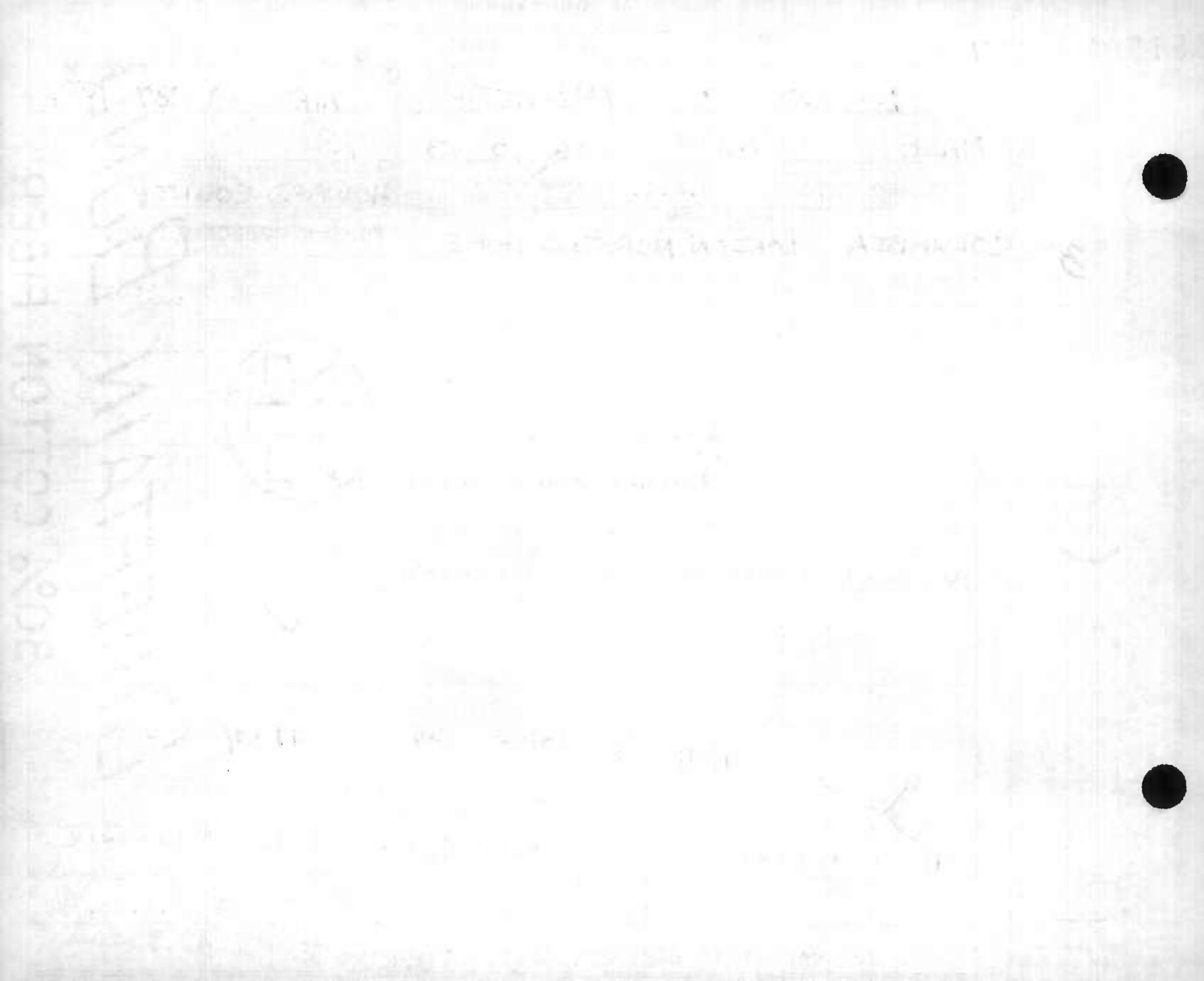
1982-1983 - 1983-1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. The private funeral carbon papers, page 4, may be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																					
8 7 REG. NO. 1 1 5 3 8																					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR												
LEONARD C. McCRAITH						APRIL 19 1987			130 PM												
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS											
MALE		CAUCASIAN		06 10 13			73 YRS			IF UNDER 24 HRS HOURS MIN.											
7b. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
CLEVELAND OHIO		U.S.A.					HOWARD COUNTY														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
COLUMBIA		LORIEN NURSING HOME										12b. KIND OF BUSINESS OR INDUSTRY Forman DOBECKMAN CO.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN EDGEMEWEATER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1429 SHORE DR. 21037	
14. FATHER'S NAME LEONARD		MIDDLE A.		15. MOTHER'S MAIDEN NAME BESSIE			16. SOCIAL SECURITY NO. 286-09-6203		17. INFORMANT JEAN P. McCRAITH		ADDRESS 1211 GREEN HOLLY DR. ANNAPOLIS, MD. 21401										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		(IF YES, GIVE RANK AND DATES) WWII		16b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia.																					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 18, stating the underlying cause lost. (b) Atherosclerotic heart disease																					
DUE TO, OR AS A CONSEQUENCE OF (c) Peptic ulcers																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18																					
benign prostatic disease Dementia																					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 10/25/1984 to 4/19/1987, that (I) (we) lost sow the deceased alive on 4/19/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE John		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED													
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R. I DESAI		22f. ADDRESS 3010 York Road Baltimore MD 21212																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-22-87			23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERANS CE.			23d. LOCATION CROWNSVILLE COUNTY A.A.C.O. STATE Md.													
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS		ADDRESS 1212 WEST ST. ANNAPOLIS			25a. DATE REC'D. BY REGISTRAR APR 24 1987			25b. REGISTRAR'S SIGNATURE Julie Dawson-Randall													
BP _____																					
DHMH - 16 60M 7/84 (VRA 15, 4)																					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ONE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF MEDICAL RECORDS, 21201 BALTIMORE, MARYLAND.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 - STATE REGISTRAR			REG. NO. 11535									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b HOUR			
ELMER RICHARD McDONALD						4	3	1987				
2. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d HOUR		
MALE		WHITE	8 8 1924	62 yrs.			4	3	1987		11:15 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
VA			U.S.A.						Howard County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Ellicott City			Municipal Parking Lot off Main St.			Handyman			Ass't.			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		MAIN STREET 21043			
MD			HOWARD	ELLIOTT CITY								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
JEFF			McDONALD			VIRGINIA			WRIGHT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 230-24-1208			17. INFORMANT LINDA McDONALD			ADDRESS 3429 PLUMTREE DR. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypothermia complicating alcoholism DUE TO, OR AS A CONSEQUENCE OF 9019 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR xx 4-3- 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Exposure to cold.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot off Main St.			21f. LOCATION STREET CITY OR TOWN Ellicott City, Howard COUNTY STATE MD						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy Chief M.D. MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/7/87		23c. NAME OF CEMETERY OR CREMATORIAL St. JOHN'S CEMETERY			23d. LOCATION CITY OR TOWN ELLIOTT CITY, HOWARD, MD			COUNTY STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS BOX 268			25a. DATE REC'D. BY REGISTRAR APR - 8 1987			25b. REGISTERED SIGNATURE				
SIACK FUNERAL HOME		ELLIOTT CITY, MD. 21043										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 1540											
1. DECEASED NAME (TYPE OR PRINT)	FIRST HELEN	MIDDLE S.	LAST MCGUIRE	2a DATE OF DEATH MONTH July	DAY 12	YEAR 1903	2b HOUR 8:25 P.M.				
3. SEX F Female	4. RACE C White	5. DATE OF BIRTH MONTH July	DAY 12	YEAR 1903	6. AGE (IN YEARS LAST BIRTHDAY) 83	YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County								
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson	12b. KIND OF BUSINESS OR INDUSTRY Dept Store								
13a STATE Maryland	13b COUNTY Howard	13c CITY OR TOWN Columbia	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 9517 Pamplona Rd 21045							
14. FATHER'S NAME FIRST John Givler	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Lillian Adams								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 162 36 7786	17. INFORMANT Mrs Don Olson	ADDRESS 9715 Pamplona Rd Columbia								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days							
DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DOUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-30 , 19 87 , to 4-2 , 19 87 , that (I) (we) last saw the deceased alive on 4-2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Krishna P. Kumar				DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P. KUMAR				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 6'87	23c. NAME OF CEMETERY OR CREMATORIAL Paxtang Cemetery	23d. LOCATION CITY OR TOWN Harrisburg Penna.	23e. COUNTY	STATE						
24. FUNERAL DIRECTOR Harry H Witzke & Family Funeral Home NAME Inc. 4112 Old Columbia Pike Ellicott City	ADDRESS	25a. DATE REC'D. BY REGISTRAR APR 9 1987	25b. REGISTRAR'S SIGNATURE Julia Sander-Randall								

4/14

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
FOR - STATE REGISTRAR											REG. NO. 11541		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH	DAY	YEAR	2b. HOUR		
			THOMAS	R.	MCMULLEN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4	28	87			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR		
Male		White	Sept. 6, 1947	39 yrs.				4	28	87	7:55A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County						
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkridge		5637 Furnace Avenue					Chauffeur Construction						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland				Baltimore				2209 Walshire Ave. 21214					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
Robert			McMullen	Naomi			Grooms						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		Vietnam		217-50-0905		Mrs. Shirley McMullen		Same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mechanical compression													
9190 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART I OR PART II)		SUBJ. driving a tractor (Farm) up metal ramp slipped off side overturning on subj.							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
		Universal Construction Inc.		5637 Furnace Ave.		Elkridge, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		<i>Margarita Korell</i> M.D. Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		5-1-87		Moreland		Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck, Inc.		Baltimore, Md.		APR 29 1987		<i>John Landau</i>							
07/B4 25M	BP												
DHMH - 17 (VR A15 ME (5))													

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1970-1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented to him.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned by the hospital or attending physician, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Please fill in by the funeral director, page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, this medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
FOR STATE REGISTRAR			8 REG. NO. 11542												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			20. DATE OF DEATH		MONTH	DAY	YEAR				
Lerenzer				McQuaige			4-10-87		APR	10	87				
3. SEX		FEMALE			LERENZER			5. DATE OF BIRTH		MONTH	DAY	YEAR			
Female		Black						1/15/40			15	40			
7b. BIRTHPLACE COUNTRY		N.C.			USA			6. AGE (IN YEARS LAST BIRTHDAY)		6. AGE (IN YEARS LAST BIRTHDAY)					
								MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
								WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		YRS					
18. CITY OR TOWN OF DEATH		Baltimore			Howard County			9. BALTIMORE CITY OR COUNTY OF DEATH		Howard Co., MD.					
11a. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Howard General						10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Nurse					
11b. STATE		Md			Howard			12b. KIND OF BUSINESS OR INDUSTRY		State Hosp. Springfield					
13a. CITY OR TOWN		Columbia						13d. INSIDE CITY LIMITS?		21845					
14. FATHER'S NAME		FIRST	MIDDLE	Mc Quaige Sr			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		6249 Kind Rain ct				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		NO			16b. SOCIAL SECURITY NO.			15. MOTHER'S MAIDEN NAME		Mc Lear					
					216-36-6739			Mary Jane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))		Sepsis						17. INFORMANT		Troy Mc Quaige					
		Due to, or as a consequence of (b) Peritonitis						ADDRESS		6249 Kind Rain ct					
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
		(c) Infected exit site.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chrome Renal Failure. Systemic Lupus Erythematosus															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>													CITY OR TOWN		
22a. I certify that (I) (this hospital) attended the deceased from 4/4/87 19		to 4/11/87 19			, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			22b. SIGNATURE James J. Carey		DEGREE			COUNTY STATE		
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		James J. Carey						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		Burial			23b. DATE 4-10-87			23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem		23d. LOCATION CITY OR TOWN Arbutus			COUNTY STATE Md		
24. FUNERAL DIRECTOR NAME		Wm. C. March F. H.			ADDRESS 4300 Wabash Ave			25a. DATE REC'D. BY REGISTRAR APR 9 1987		25b. REGISTRAR'S SIGNATURE					

4/14

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		8 REG. NO. 11543							
1 DECEASED NAME (TYPE OR PRINT)		FIRST Harry D	MIDDLE moore	LAST	2a DATE OF DEATH 4 14 87	MONTHS	DAY	YEAR	2b HOUR 12:20 AM
3 SEX MALE		4 RACE CAUC		5. DATE OF BIRTH MONTH 8 DAY 31 YEAR 29		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing		12b KIND OF BUSINESS OR INDUSTRY Self-employed			
13a STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 742 Edmondson Ave. 21228	
14 FATHER'S NAME FIRST Harry		MIDDLE Moore	LAST	15 MOTHER'S MAIDEN NAME FIRST Lucille		MIDDLE	LAST Mozingo		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 250-36-4344		17 INFORMANT Mrs. Lois Moore - same as #13		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Squamous Cell Cancer of lung - metastatic (c)								3 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pleural effusion, Pericardial effusion, Laryngeal Crachis									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from Jan 1986 to April 19 1987, that (I) (we) last saw the deceased alive on April 13 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jon K. Mifflin		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-14-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon K. Mifflin MD		22e ADDRESS 10809 Hickory Ridge Rd Columbia MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 4-14-87		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		23e COUNTY STATE	
24 FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR APR 15 1987		25b. REGISTRAR'S SIGNATURE Julia Sanderson-Lindsey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be completed by the attending physician or certifying physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the burial permit. Then please remove carbon copy of page 3 and attach it to the burial permit. This will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, no medical examiner will be retained or used.

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1892-1893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, interment or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
8 7 REG. NO. 11544															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	12b. HOUR				
ELLA KATHERINE NICHOLSON						4/14/87					12:30A.M.				
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White			MONTH 12 DAY 17 YEAR 03			83			MONTHS	YRS.	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.						Howard							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Ellicott City		9105 Winding Way						Housewife			Domestic				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21043			
Md.		Howard		Ellicott City					9105 Winding Way						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
		William		Coulling				Ella	Katherine	Powers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		215-16-5844			Katherine Rose			9105 Winding Way Ellicott City, Md. 21043			3 years				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatic carcinoma</u>															
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiopulmonary arrest</u>												15 minutes			
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 4-1 1986</u> , to <u>April 19 1987</u> , that (1) (we) last saw the deceased alive on <u>4-1 1987</u> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>4-14-87</u>			
22b. SIGNATURE <u>William M. Russell MD</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILLIAM M. RUSSELL MD</u>			22e. ADDRESS <u>2521 WASHINGTON BLVD BALTO.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 4/17/87		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park			23d. LOCATION CITY OR TOWN Woodlawn Balto.			COUNTY Md. STATE					
24. FUNERAL DIRECTOR HARRY H WITZKE & FAMILY FUNERAL HOME, INC.		4112 OLD COLUMBIA PIKE ELLIOTT CITY MD 21043			25a. DATE REC'D. BY REGISTRAR APR 15 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Sander-Landau</u>							

4120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be transmitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 14545											
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST		
I. DECEASED NAME (TYPE OR PRINT)			ESTHER S			NORD					
3. SEX Female			4 RACE WHITE			5. DATE OF BIRTH MONTH 7 DAY 2 YEAR 98			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.		
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD County GENERAL Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS / ZIP CODE 6420 Woodburn Ave. 21227		
14. FATHER'S NAME FIRST Carl			MIDDLE F.			LAST Kullman			15. MOTHER'S MAIDEN NAME FIRST Nina		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 012-10-0285			17. INFORMANT Eric R. Nord			ADDRESS 334 Gatewater Court. Glen Burnie, Maryland 21061		
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and 1(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Aspiration pneumonia 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Organic brain syndrome.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 OR PART 1) saw the deceased alive on 4/6/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			20c. IF YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan 1985 to 4/7/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/7/87		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sadiq			22f. ADDRESS Howard County General								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-11-87			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Prk.			23d. LOCATION CITY OR TOWN Elkridge, Maryland 21227		
24. FUNERAL DIRECTOR NAME Gary L. Kaufman Funeral Home			25a. DATE REC'D. BY REGISTRAR APR 14 1987			25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return certificate, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
141 FOR 14-487 STATE REGISTRAR ELLEN PALMATARY			ELLEN	H.	PALMATARY		April	25	1987	12	PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		white		MONTH DAY YEAR			90			MONTHS	DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
Delaware		USA		5 21 1876			Kent Co						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Chestertown		Magnolia Hall Nursing Center								Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
MD		Queen Anne		Church Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.D.1 Box 145 21623			
14. FATHER'S NAME		FIRST	MIDDLE	LAST			15. MOTHER'S MAIDEN NAME			LAST			
Jonathan		L.		Hopkins			Mary			Jewell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO		-		221-14-4023			Louis J. Palmatary			R.D. 1 Box 145 Church Hill, MD 21623			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>arterio sclerotic cardiovascular disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>4/10/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>4/25/87</u>	
22b. SIGNATURE <u>Robert W. Farr</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert W. Farr</u>			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>4/28/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Hollywood Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Chestertown</u> COUNTY <u>Md</u> STATE <u>-</u>						
24. FUNERAL DIRECTOR NAME <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>APR 29 1987</u>			25b. REGISTRAR'S SIGNATURE <u>J. Willis Wells</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, it should be detached for use as the burial transit permit. Then please remove carbon paper. Page 4 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

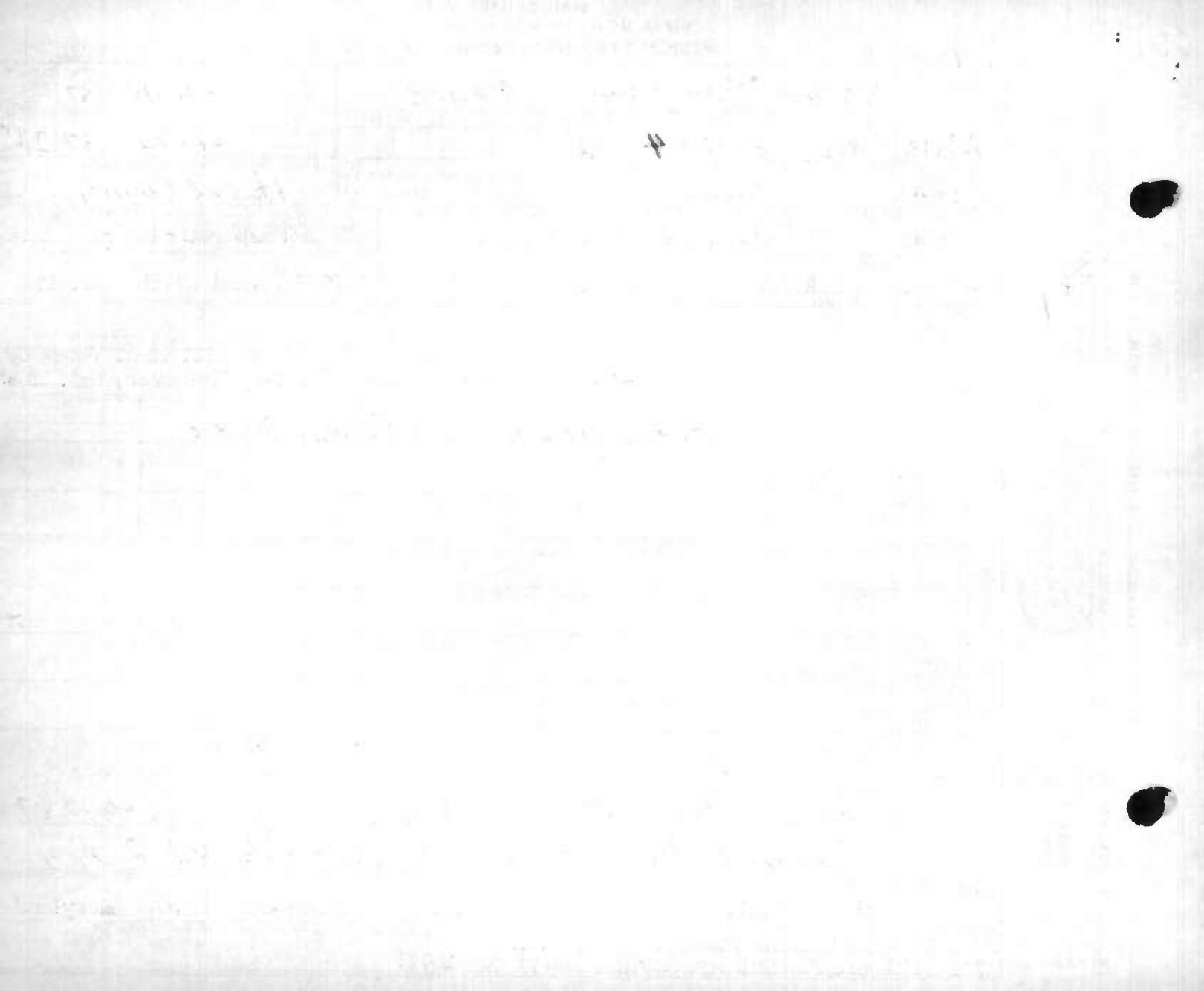
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8711547					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Anne</i>			<i>M.</i>	<i>Park</i>			4 4 87						1101 PM				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
<i>F</i>			<i>W</i>		MONTH 6 DAY 8 YEAR 61			85			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
<i>Delaware</i>			<i>USA</i>						<i>Howard County</i>			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
<i>Columbia</i>			<i>Howard County General Hospital</i>			<i>Homemaker</i>											
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
<i>Md</i>			<i>Howard</i>		<i>Ellicott City</i>		YES <input type="checkbox"/> NO <input type="checkbox"/>			<i>9425 Dunloggin Rd. 21043</i>							
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
<i>Bruce</i>				<i>Laurenson</i>	<i>Mary</i>				<i>Peterson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No			<i>148189286</i>			<i>Kenneth Park</i>			<i>9425 Dunloggin Rd. 21043</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>95 min</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>414 St</i> CITY OR TOWN <i>414 St</i> COUNTY <i>Howard Co</i> STATE <i>MD</i>											
22a. I certify that (I) (this hospital) attended the deceased from <i>4/4/87</i> to <i>4/4/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Alan G. Stahl, MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23. DATE SIGNED <i>4/4/87</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alan G. Stahl</i>			22e. ADDRESS <i>Columbia Medical Plaza</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>4/8/87</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Harleigh Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Camden</i> COUNTY <i>N.J.</i> STATE <i>N.J.</i>								
24. FUNERAL DIRECTOR <i>Harry H Witzke & Family Funeral Home, Inc.</i>			25a. DATE REC'D. BY REGISTRAR <i>4/12/87</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

4/14

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGES 1, 2, AND 3 SHOWN AND BE FILLED WITH FORM FM 3. RETAIN PAGES 1, 2, AND 3 SHOWN AND BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 5 4 8												
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			2a. DATE KNOWN OF DEATH ESTI- MATED				MONTH	DAY	YEAR	2b. HOUR									
Walter Benjamin Payne								<input checked="" type="checkbox"/> 4-15				19	87	245										
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		Cauc.		6-12-15 71			YRS.		MONTHS		DAYS		HOURS		MIN.		4-20		19		87		245	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED										9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		U.S.A.		<input checked="" type="checkbox"/>										Howard County, MD.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. HOUSE OF INDUSTRY										
Columbia		6150 Foreland Garth Apt. 318										Elevator Operator		Representative										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS														
Maryland		Howard		Columbia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				6150 Foreland Garth Apt. 318														
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST				MIDDLE		LAST												
Walter				Payne		Margaret						Finall												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS																				
Yes		578-16-8183		Mildred Lloyd (Sister) Landover, Md. 20784																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . and in my opinion																								
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER														DATE SIGNED								
EXAMINER'S NAME (TYPE OR PRINT)		Thomas F. Herbert, MD														4-20-87								
EXAMINER'S ADDRESS		Ellicott City, Md. 21043																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE										
Burial				04/23/87		Fort Lincoln Cemetery				Brentwood		P.G.		Maryland										
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR														25b. REGISTRAR'S SIGNATURE						
Francis Gasch's Sons Funeral Home, P.A.				APR 24 1987														Julia Scardon-Randall						
4739 Baltimore Avenue Hyattsville, Maryland				20781																				
BP		DHMH - 17		(VR A15 ME (5))		20M 4/82																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "D", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
87 11549 REG. NO.												
1 - STATE REGISTRAR			MATTHEW PYNE			2a. DATE OF DEATH			MONTH 4 DAY 16 YEAR 87			
(2)						Pyne			2b. HOUR 855 AM			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST								
Mathew												
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR	
Male		WHITE			MONTH 8 DAY 6 1895 08 06 95			91 YRS.			855 AM	
7a. BIRTHPLACE & MAJOR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
England		GREAT BRITAIN						Howard County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbin		Lorien Nursing Home						PRINTER			NEWSPAPER	
USUAL RESIDENCE (IF NOT IN HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
MD		Baltimore		Columbia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			246 GLENMORE AVENUE 21228			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS				
John				Pyne	Rebecca			2555 SAND HILL ROAD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ELLICOTT CITY, MD. 21043				
NO		212-34-3031			DORA CRAWFORD							
18. CAUSE OF DEATH: Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF LUNG</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>Chronic Obstructive Pulmonary Disease</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
								COUNTY			STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>1984</u> to <u>1987</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>4.14.87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.												
22b. DATE SIGNED <u>4.15.87</u>												
24. PHYSICIAN'S NAME (TYPE OR PRINT)		25. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
TED DADISMAN		M.D.						COLUMBIA, MD. 21045				
								PATUXENT MEDICAL GROUP - 2 KNOLL NORTH DRIVE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
CREMATION		4/17/87			WESTVIEW CREMATORIAL			CATONSVILLE				
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A.								APR 21 1987				
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228												
(VRA 15, 4)												

1110



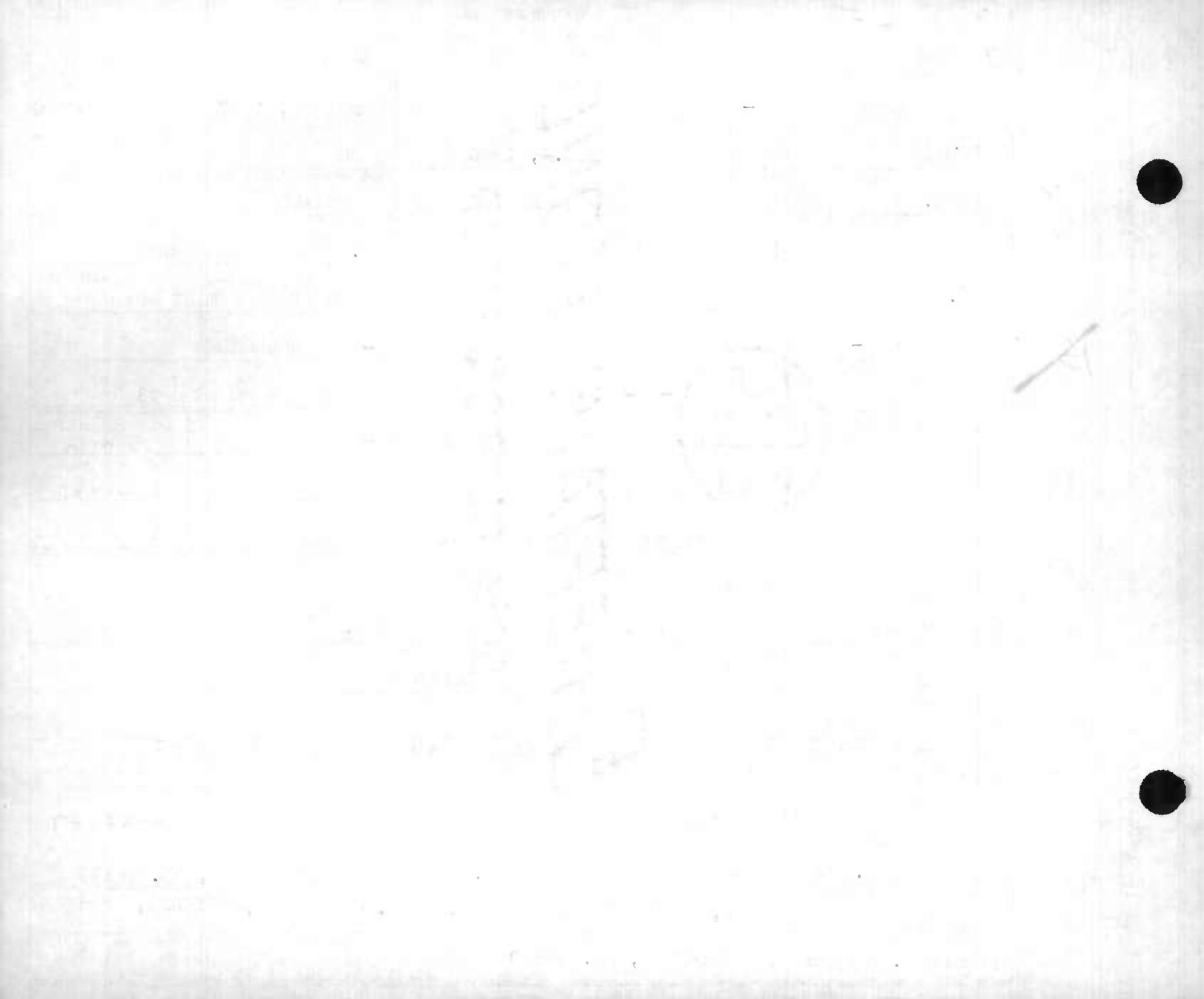
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3, it should be detached from us or the Funeral Director's page 3, then please remove carbon paper. Please sign and date page 3 and attach it to the death certificate and within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury or other traumatic event, the doctor certifying the cause of death must sign below.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8711550			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
LYDIA					RAISCH	April 28, 1987				10:30AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR DEC. 4, 1896		90		MONTHS DAYS		HOURS MIN.			
YRS.													
7a. BIRTHPLACE COUNTRY PENN.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD		MD.					
10. CITY OR TOWN OF DEATH DAYTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5115 GREENBRIDGE ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. MAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME							
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19603 SPARR SPRING ROAD		20879			
FATHER'S NAME EDWARD		MIDDLE - SCHROEDER		LAST		15. MOTHER'S MAIDEN NAME AMILIA		MIDDLE - SCHROEDER		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) NO		16b. SOCIAL SECURITY NO. 526-92-1039		17. INFORMANT VIRGINIA RABENHORST		ADDRESS SAME AS # 13							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dehydration</u> 2 weeks													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u> 5 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>None</u>													
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) N/A									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> , 19 <u>89</u> , to <u>4-28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jay S. Morrow</u>		DEGREE MD.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 4-28-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAY S. MORROW		22e. ADDRESS MONT. VILLAGE GAITHERSBURG, MD. 20879											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 2, 1987		23c. NAME OF CEMETERY OR CREMATORIUM GREEN ACRES MEM. GARD.		23d. LOCATION SCOTTSDALE, MARICOPA, ARIZONA							
24. FUNERAL DIRECTOR MURIEL H. BARBER		LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR APR 30 1987		25b. REGISTRAR'S SIGNATURE <u>Muriel H. Barber</u>							



10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed with 24 hours after death.

11. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 REG. NO. 1 1 6 5
DATE OF DEATH MONTH DAY YEAR HOUR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
		George Walter Reihl			April 24, 1987						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Male		White		February 7, 1948		39 YRS.					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U.S.A.				Kent County					
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent-Queen Anne's Hospital				Waterman					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Kent		Rock Hall				Box 387, Mercer Avenue 21661			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Elmer Leroy Reihl						Rose Leona Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT ADDRESS							
Yes		Vietnam		218-48-8148		Dusetta Carol Reihl, same as above					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <i>status asthmaticus</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		DUE TO, OR AS A CONSEQUENCE OF (b) _____									
		DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE WORKING <input type="checkbox"/> NOT WHILE WORKING		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mark Bienefeld MD</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Michael Bienefeld		22e. ADDRESS Medical Building, Chestertown, MD 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04-27-87		23c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cemetery		23d. LOCATION CITY OR TOWN Rock Hall		COUNTY Kent		STATE MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Rock Hall, MD 21661		25a. DATE REC'D. BY REGISTRAR MAY 4 - 1987 <i>John DeLoach, R.N.</i>				25b. REGISTRAR'S SIGNATURE					
DHMH - 16 60M 7/84 (VRA 15, 4)											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows injury or other traumatic event, if medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 7 REG. NO. 1 1 5 5 2												
1 - STATE REGISTRAR		ROBERT A. SCHREMP										
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOW	
Robert		A.		Schremp		4/18/87		4	18	1987	930 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		White		MONTH 8 DAY 11 YEAR 97		79		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
New York		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Howard County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Columbia		Howard County General Hospital C.P.A./ Gov't Accounting Office										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		MD.		
Maryland		Montgomery		Sandy Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Sandy Spring		17300 Quaker Lane B-13		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Alfred				Schremp		Mary				Eustace		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
NO		066-07-6355		Lori Whichard		Md. 21029						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Arrest										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident 2nd cerebromedullary												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured aortic aneurysm												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) General Atherosclerosis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from 4/10/87, 19, to 4/18, 1987, the (I) (we) last saw the deceased alive on 9/18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Melvin J. Kardon MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Columbia, Md. 21046		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Kardon MD		22e. ADDRESS 2000 Centenary Plaza Columbia, Md. 21046										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/22/87		23c. NAME OF CEMETERY OR CREMATORIAL St. Louis Church Cemetery		23d. LOCATION Clarksville		CITY OR TOWN		COUNTY		
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Home		25a. DATE REC'D. BY REGISTRAR APR 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall								
DHMH - 16 60M 7/B4 (VRA 15, 4)												

3

109-1589A

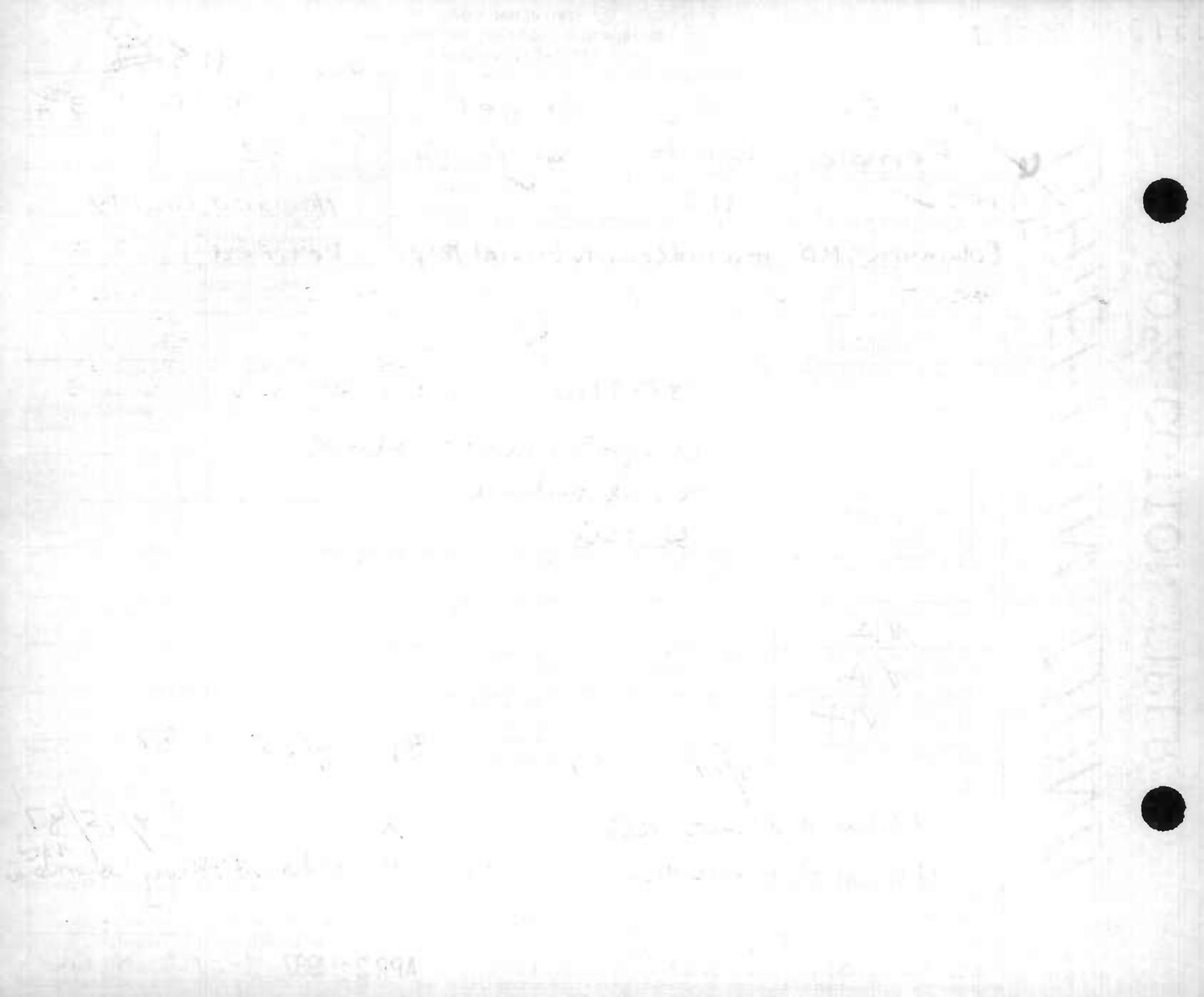
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows injury, or other traumatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	HOUR	REG. NO.	
Evelyn B. Seigel						4-15-87				3 AM	115 53	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White	MONTH	DAY	YEAR	82 YRS.	MONTHS	DAYS	MONTHS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		US						Howard County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia, MD		Howard County General Hosp.			Retired			AT HOME				
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 6150 FORELAND GARTH APT. 319				
14. FATHER'S NAME FIRST		WILLIAM HAYS		MIDDLE		15. MOTHER'S MAIDEN NAME MINNIE		UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 215-03-5996		17. INFORMANT MR. JULIUS SEIGEL APT. 319 6150 FORELAND GARTH COLUMBIA, MD 21045								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>sepsis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 81 to 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE William Flowers MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 11055 Little Patuxent Pkwy Columbia MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR. 16, 1987		23c. NAME OF CEMETERY OR CREMATORIAL BETH EL MEM. PARK		23d. LOCATION CITY OR TOWN RANDALLSTOWN		COUNTY BALTO.		STATE MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR APR 21 1987		25b. REGISTRAR'S SIGNATURE elia Davidson-Randall								



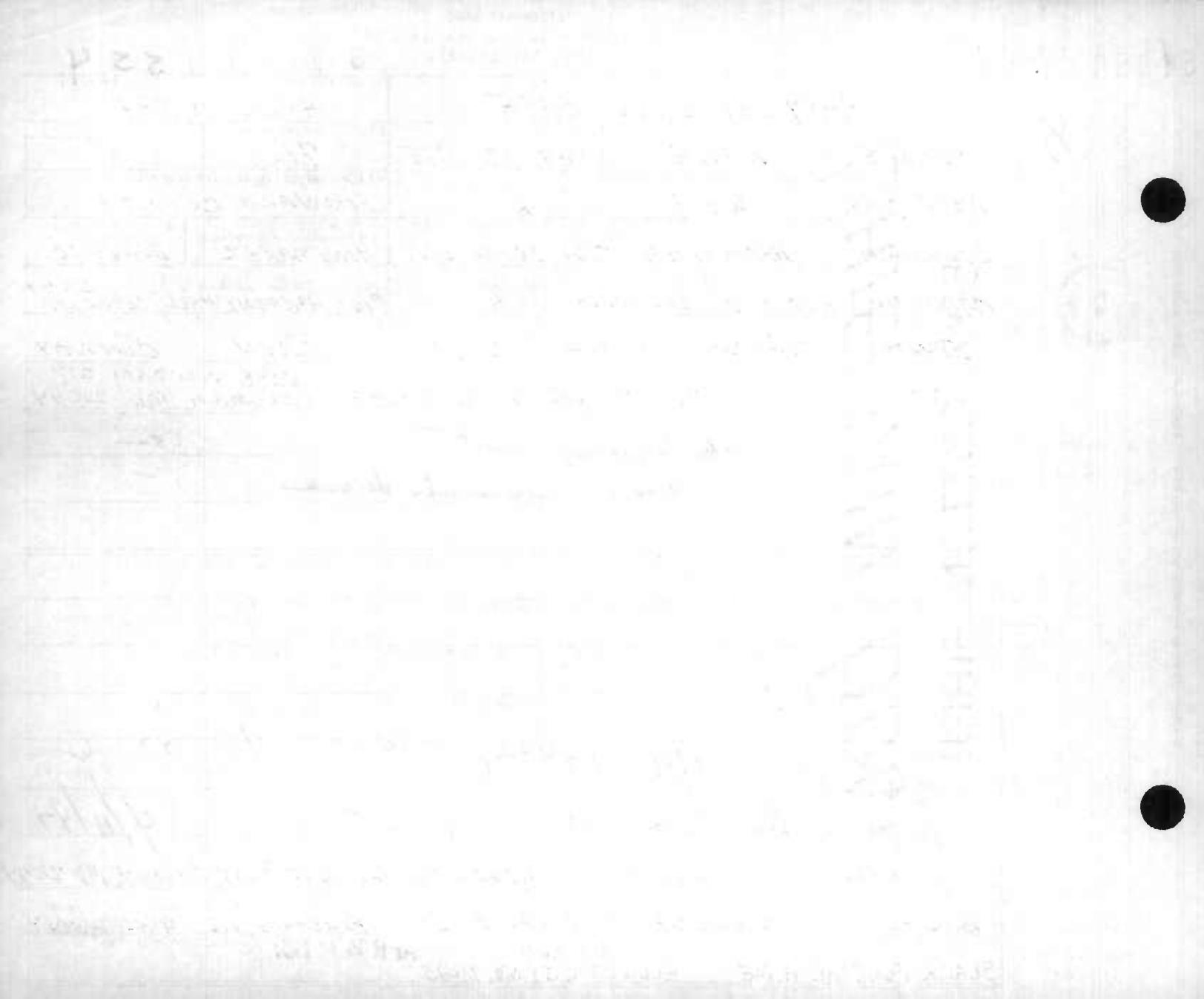
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1, 2, 3, and 4 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
87 REG. NO. 11554									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			
MARGARET ELLEN SHEA						APRIL 11, 1987			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			
FEMALE		WHITE		MAY 22 1915		71 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.			
NEW YORK		U.S.A.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
COLUMBIA		HARMONY HALL #161, CEDAR LN.				HOMEMAKER			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MARYLAND		HOWARD		COLUMBIA		13e. STREET ADDRESS / ZIP CODE #161 HARMONY HALL, CEDAR LN. 21044			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
EDWARD		FRANCIS		WALL		SUSAN ELLEN CONWAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
NO		053-09-0632		EDWARD F. SHEA				5208 WOODAM CT. COLUMBIA, MD. 21044	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio - Respiratory Arrest</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASWD - Atherosclerotic disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> (did not) <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 3/13/1987 to 4/19/87 , that (I) (we) lost saw the deceased alive at above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Warren M. Ross, M.D.</i>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN M. ROSS, M.D.		22e. ADDRESS 11065 LITTLE PATUXENT PKWY, COLUMBIA MD 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 15 APRIL 87		23c. NAME OF CEMETERY OR CREMATORIAL MT. ST. MARY'S CEM.		23d. LOCATION CITY OR TOWN FLUSHING LI. QUEENS NY		COUNTY	STATE
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 268 ELLIOTT CITY, MD. 21043				25a. DATE REC'D BY REGISTRAR APR 27 1987			
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1a. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF FUNERAL ENFORCEMENT, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11555	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>-Martin</i>	MIDDLE	LAST <i>TALAN</i>	20. DATE KNOWN OF ESTI. DEATH MATED			MONTH 4	DAY 20	YEAR 1987	2d HOUR 22	
3. SEX MALE			RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 1, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN	2d DATE PRONOUNCED DEAD			2d HOUR 22
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>				
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK (FOR MOST CONVENIENT LIFE)) EXECUTIVE			12b. KIND OF BUSINESS OR INDUSTRY PRINTING				
13. STATE NEW YORK			13b. COUNTY NEW HYDE PARK			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 11 CARLING DR.				
14. FATHER'S NAME FIRST JACOB			MIDDLE	LAST TALAN	15. MOTHER'S MAIDEN NAME FIRST TESSIE			MIDDLE	LAST BERNSTEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT MRS. SHIRLEY TALAN			ADDRESS NEW HYDE PARK, N.Y.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) <i>Chronic myocardial disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas F. Herbst</i>			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER <i>Deputy</i>			DATE SIGNED 4-20-87				
EXAMINER'S NAME (TYPE OR PRINT) <i>Thomas F. Herbst, MD</i>			ADDRESS <i>Ellicott City, MD 21043</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL / REMOVAL			23b. DATE 4/22/87			23c. NAME OF CEMETERY OR CREMATORIAL BETH MOSES CEM.			23d. LOCATION CITY OR TOWN PINELAWN, L.I. N.Y.				
24. FUNERAL DIRECTOR NAME 6010 REISTERSTOWN RD. BALTO., MD. (21215)						25a. DATE REC'D. BY REGISTRAR APR 28 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Laddie</i>				

2000 COULD NOT BE
MADE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 will be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
87 REG. NO. 556												
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	
Charles Paul Truitt						4	30	87				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR	
Male			White		MONTH	DAY	YEAR	70	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.						Howard County MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Ellicott City			4918 Eastwood Place 21043			Retired McCormick Spice Co						
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4918 Eastwood Place 21043			
14 FATHER'S NAME FIRST John H Truitt Sr.			LAST			15 MOTHER'S MAIDEN NAME FIRST Elizabeth M Westenofer			LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17 INFORMANT Jim H Gardner			ADDRESS 21229 Maiden Choice La. Baito Mo			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE ACUTE CORONARY OCCLUSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CORONARY ARTERY DISEASE, CHRONIC												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from 7/1/1987 to 7/30/1987, that (2) we last saw the deceased alive on 3/5/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.												
22b. SIGNATURE <i>Brad J. Cooper, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brad J. Cooper, M.D.			22e. ADDRESS 2850 N. RIDGE RD. ELICOTT CITY MD. 21043									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE May 4, 1987			23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral			23d. LOCATION CITY OR TOWN Baltimore			
23e. BURIAL, CREMATION, REMOVAL (SPECIFY)			23f. DATE Burial			23g. NAME OF CEMETERY OR CREMATORIAL New Cathedral			23h. LOCATION CITY OR TOWN Maryland			
24. FUNERAL DIRECTOR HARRY R. WITZKE & FAMILY FUNERAL HOME, INC.			25a. DATE REC'D. BY REGISTRAR MAY 6 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>						
NAME HARRY R. WITZKE & FAMILY FUNERAL HOME, INC.			ADDRESS 4112 OLD COLUMBIA PIKE ELICOTT CITY MD 21043									

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and nineteenth in the fourteenth

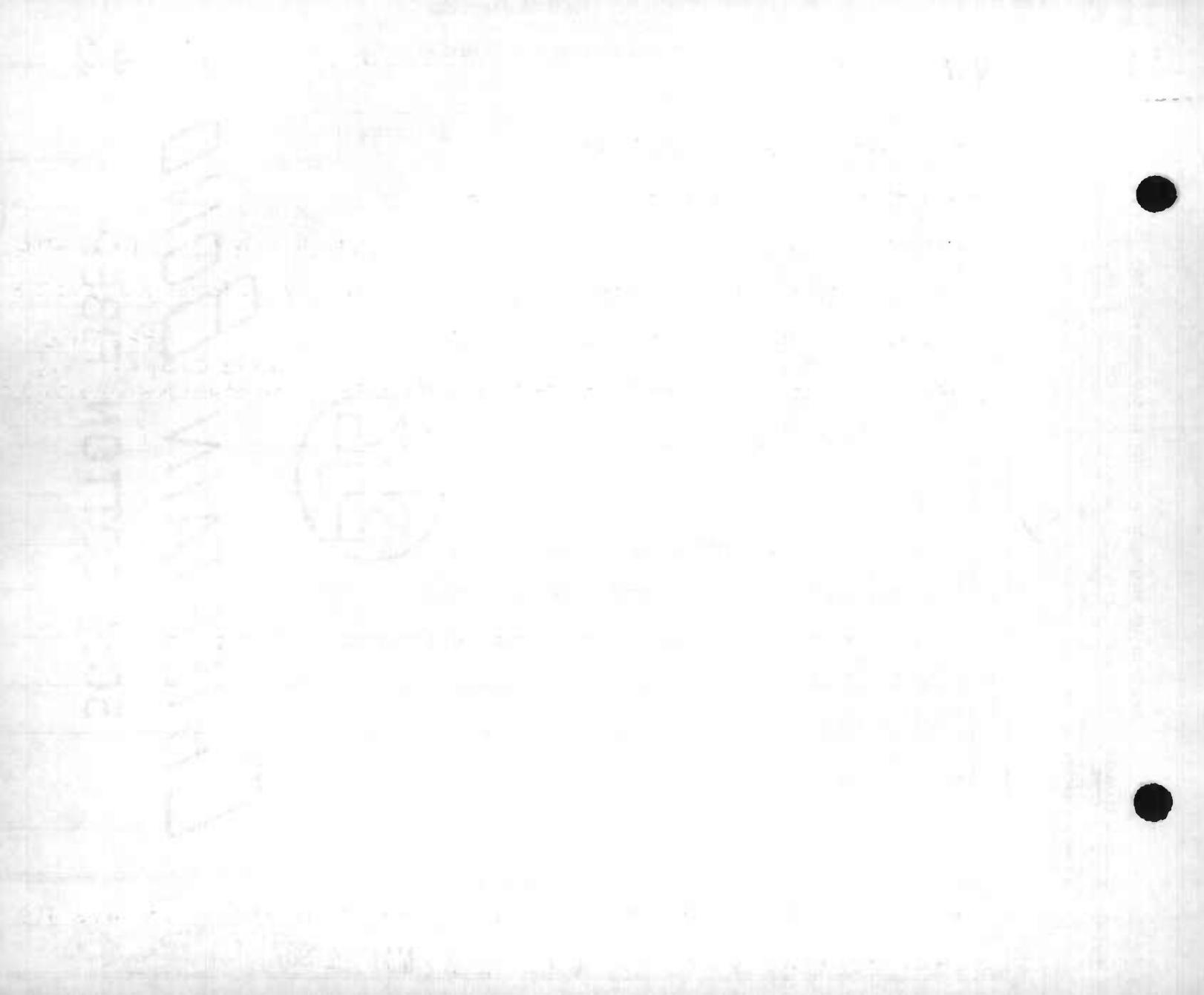
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3, RETAIN PAGE 1 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RIG. NO. 559

1 - STATE REGISTRAR		2a. DATE KNOWN OR ESTIMATED MONTH DAY YEAR		2b. HOUR	
DECEDENT NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		4 29 1987	
Ruby V. Tucker					
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN 3 1907	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Waterloo		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harmon's Boarding Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN Waterloo	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 60739 Waterloo Rd. 21227			
14. FATHER'S NAME FIRST Joseph		MIDDLE W.		LAST Harrison	
15. MOTHER'S MAIDEN NAME FIRST Olivia					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-05-2427		17. INFORMANT Fern Poblets	
				ADDRESS 3313 Chapman Rd. Randallstown MD 21133	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus Seizure disorder					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) William M. ZANE, M.D.					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 2 May 87		23c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd Cem.	
23d. LOCATION CITY OR TOWN Ellicott City		23e. COUNTY Howard		23f. STATE MD	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS 111 Penn St. Balto. MD.		25a. DATE REC'D. BY REGISTRAR 2 MAY 1987	
				25b. TECHNICIAN'S SIGNATURE Julia Wilson-Randall	

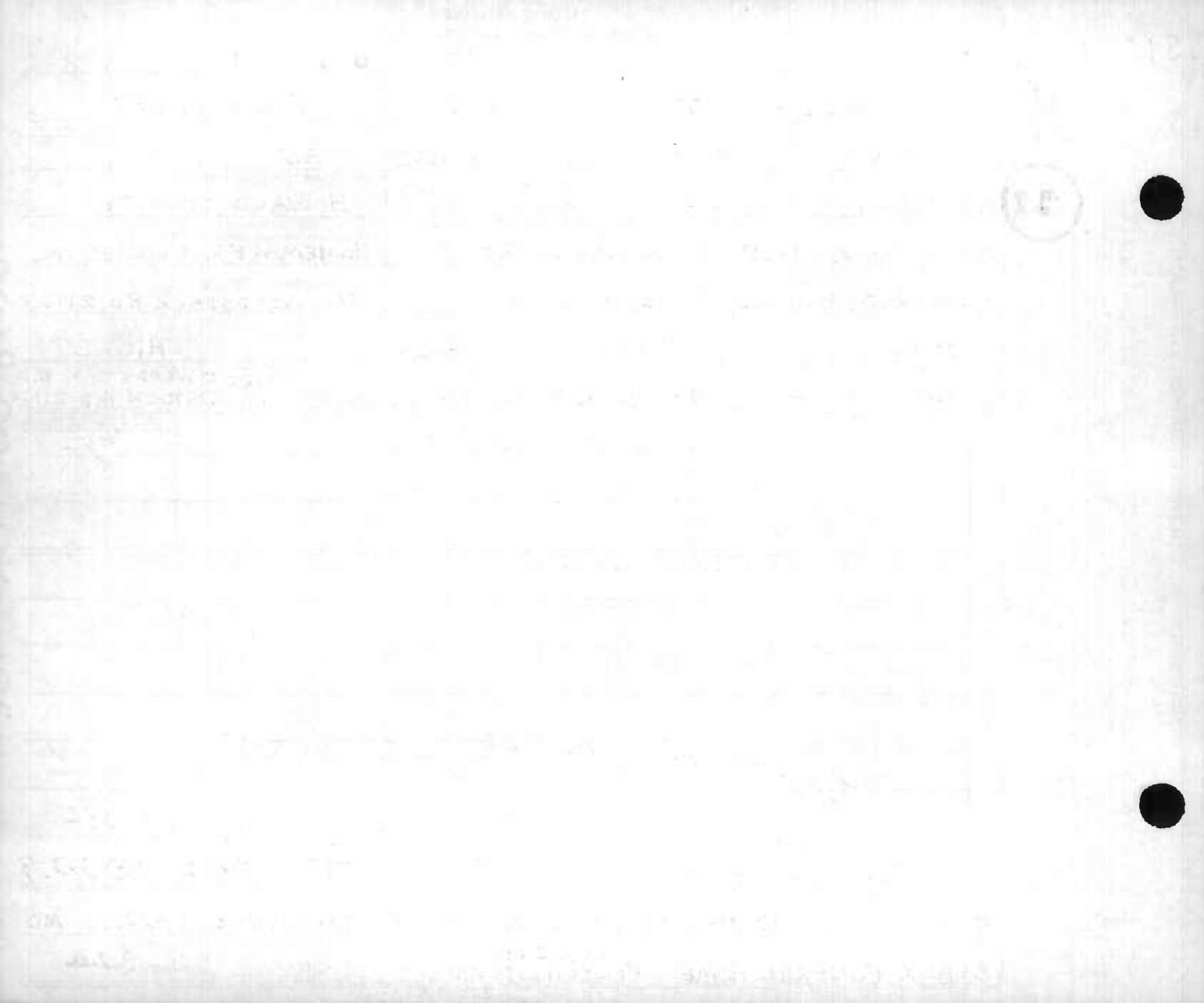


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 7 REG. NO. 1 1 5 5 8											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					
NELLIE T VOLAND						APRIL 15, 1987					
3. SEX			4 RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)						
FEMALE			WHITE	MARCH 25, 1932	55 YRS.						
BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8	9. BALTIMORE CITY OR COUNTY OF DEATH						
KENTUCKY			U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	HOWARD COUNTY MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
WOODSTOCK			1580 WOODSTOCK RD.			HOMEMAKER			DOMESTIC		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE					
MARYLAND			HOWARD	WOODSTOCK	1580 WOODSTOCK RD. 21163						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
JOHN			SALLY HICKS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			400-40-4280			DAVID F. VOLAND			1580 WOODSTOCK RD. WOODSTOCK, MD. 21163		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of lung</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7yr</i>											
DUE TO, OR AS A CONSEQUENCE OF { (b) { DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-24-87</i> , 19 <i>87</i> , to <i>4-15-87</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>4-10-87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (not) (have) (seen) (the) body after death.											
22b. SIGNATURE <i>Paul Gorenstein</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/17/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul Gorenstein</i>			22e. ADDRESS <i>900 Linn St. Bldg. No. 2229</i>								
23a. BURIAL, CREMATION, REMOVAL SPECIAL			23b. DATE 18 APRIL 87			23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEM. PK.			23d. LOCATION CITY OR TOWN SYKESVILLE COUNTY CARROLL STATE MD		
BURIAL			18 APRIL 87			LAKEVIEW MEM. PK.			SYKESVILLE CARROLL MD		
24. FUNERAL DIRECTOR NAME <i>SLACK FUNERAL HOME</i>			ADDRESS <i>BOX 2683 ELICOTT CITY MD</i>			25a. DATE REC'D. BY REGISTRAR APR 24 1987			25b. REGISTRAR'S SIGNATURE <i>in Davidon Randalles</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
87 REG. NO. 559											
1 - FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>James</i>	MIDDLE <i>J.</i>	LAST <i>Whalen</i>	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>7 22 02</i>			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisconsin</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i>		
10. CITY OR TOWN OF DEATH <i>Fulton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Clarkson Drive</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>President</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Whalen Company</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Howard</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>Clarkson Drive 20759</i>		
14. FATHER'S NAME FIRST <i>Edward</i>			MIDDLE <i></i>	LAST <i>Whalen</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Margaret</i>			MIDDLE <i></i>	LAST <i>Fitzgerald</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>390-05-8117</i>			17. INFORMANT <i>Alice W. Whalen wife</i>			ADDRESS <i>same as #13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic prostate cancer</i> 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic lung disease, Paroxysmal atrial fibrillation</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (his hospital) attended the deceased from <i>2/9 1987</i> to <i>4/30 1987</i> , that (I) <input type="checkbox"/> did not see the deceased alive on <i>4/22 1987</i> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <i>Jules R. Lodish, M.D.</i>			22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>5/1/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jules R. Lodish, M.D.</i>			22e. ADDRESS <i>2901 Olney-Sandy Spring Rd., Olney, Maryland</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>May 7, 1987</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Matthews Church Cem. Scullsburg Lafayette Wiscons-</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>in</i>		
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 7 1987</i>			25b. DECONTRACTS SIGNATURE <i>Julia Dandrea-Randall</i>					
ADDRESS <i>500 University Blvd. West, Silver Spring, Md</i>											

and 8000 ft. 100

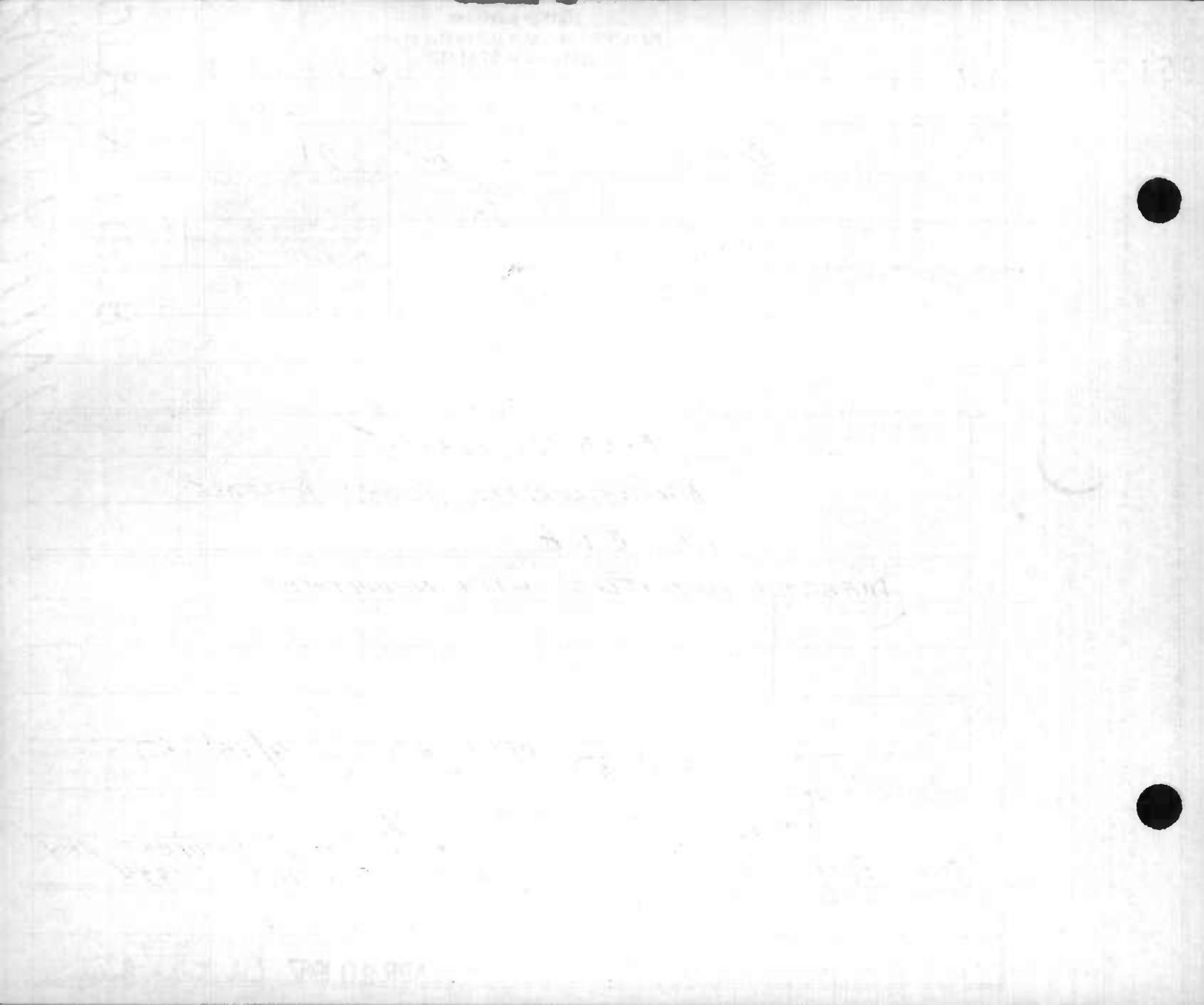
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble, call the medical examiner and the medical board if notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - STATE REGISTRAR			87 REG. NO. 15568											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
BERNARD H. WILLIAMS								4/15/87						
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR		8 04 05		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.						
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10363 LAUNCELOT LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10363 Launcelot Lane 21044						
14. FATHER'S NAME John		LAST		15. MOTHER'S MAIDEN NAME Williams		FIRST		MIDDLE		LAST		Collins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-03-5748		17. INFORMANT Francis Harris		ADDRESS 10363 Launcelot Lane								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) <i>ARTERIOSCLEROTIC HEART DISEASE</i>														
(c) <i>R.I. CVA</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>DIABETES MELLITUS WITH NEUROPATHY</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (the hospital) attended the deceased from <i>4/12/87</i> , to <i>4/15/87</i> , that (I) (we) lost saw the deceased alive on <i>4/12/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>G.W. RUEFEL</i>		22c. DEGREE MD		ATTENDING <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.W. RUEFEL		22e. ADDRESS 10840 LITTLE PATUXENT PKY COLUMBIA, MD. 21044												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/20/87		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.		23d. LOCATION CITY OR TOWN Baltimore, Md.		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOME		25a. ADDRESS 4300 Wabash Avenue		25b. DATE REC'D. BY REGISTRAR APR 20 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Jackson-Ruefels</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remember to return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial. If item 18 is marked or item 19 is checked, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 11561													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LASI			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
PAULINE YOUNG						APRIL 4, 1987			8:55P. M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
FEMALE		CAUCASIAN		NOV. 20, 1911			75			YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH KAKXXX HOWARD COUNTY MD.						
10. CITY OR TOWN OF DEATH ELLIOTT CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3158 WEST SPRINGS DR., APT. F		12a. USUAL OCCUPATION HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME						
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLIOTT CITY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3158 WEST SPRINGS DR., APT. F (21043)			
14. FATHER'S NAME FIRST DAVID		MIDDLE KERMISCH		15. MOTHER'S MAIDEN NAME ESTHER			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-30-2941		17. INFORMANT MRS. FAY KLEMPNER			ADDRESS 3719 MIDHEIGHTS XX.RD.XXXX 21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration 912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive bleeding (c) Metastatic jaw carcinoma												ACUTE ACUTE 2 years? 1987	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION MAY 1985		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca jaw		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 8-4 , 19 76 , to 4-4 , 19 87 , that (I) (we) last saw the deceased alive on 12-30 , 19 86 , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE H. Gerald Oster		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4-7-87						
22e. ADDRESS 3635 Old Court Road													
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 4/6/87		23c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD CEMETERY			23d. LOCATION CITY OR TOWN BALTIMORE			COUNTY STATE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		25a. DATE REC'D. BY REGISTRAR APR 9 1987		25b. REGISTRAR'S SIGNATURE Woodson-Randall									
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign by the attending physician and completely fill in by the funeral director. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Then please attach to burial or cremation papers. Then please attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, this medical certificate must be filed at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1 - STATE REGISTRAR		8 7 REG. NO. 1 1 562																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	HOUR							
Grace Gertrude Zinser						4	2	87			5:10 A.M.								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
Female		White		MONTH	DAY	YEAR	88 YRS												
7. BIRTHPLACE COUNTRY		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		Howard MD.												
Md.		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Elicott City		Bon Secours Nursing Home			13. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE		1013 Marleigh Cir. 21204				
Md.		Balto.			Balto.								15. MOTHER'S MAIDEN NAME		Margaret Fallon				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
John Murray					215-34-6129		George E. Zinser, Same as 13e												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - pulmonary arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u>										2 yrs.									
(c) <u>Organic brain syndrome</u>										5 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> 19 <u>86</u> , to <u>4/1</u> 19 <u>87</u> , that (we) lost saw the deceased alive on <u>4/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										22c. DATE SIGNED									
22b. SIGNATURE <u>Charles C. Sheehan M.D.</u>										DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
Charles C. Sheehan M.D.										10802 Hickory Ridge Rd. Columbia Md. 21044									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE								
Burial		4-6-87		Holy Redeemer			Balto., Md.												
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>										25a. DATE REC'D. BY REGISTRAR									
										25b. REGISTRAR'S SIGNATURE <u>APR - 3 1987</u>									

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